

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

03198 Item 7 Film G213 4-3-57 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

03189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesterly c. LENGTH OF STAY IN 1b 1 Mr 10 Min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY New York City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City d. STREET ADDRESS 273 W 38th St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Adams		4. DATE OF DEATH Month Day Year March 16 19 57					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Unknown	8. DATE OF BIRTH 7-3-89	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steward		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marines		11. BIRTHPLACE (State or foreign country) New York City			
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. 568 24 4973		17. INFORMANT Charles E. Brewer Address Bowie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 hr 1 yr. year							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 3-16-57 , 19 57 , to March 16 , 19 57 , that I last saw the deceased alive on March 16 , 19 57 , and that death occurred at 10:40 P , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 Gallatin st Hyattsville Md DATE SIGNED ACTUAL SIGNATURE Vik Bergeman M.D. PHYSICIAN'S NAME (Type) Dr. T. Bergeman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			
22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE Mar 26 57			
24b. REGISTRAR'S SIGNATURE Carl Leavelle							

RECEIVED

MAR 26 1957

BUREAU V. I.

16 March 1957

Dr. John T. Maloney Deputy Med Examiner Prince George Co. Notified and released

BH

CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MEDICAL CERTIFICATION

03199										MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03190 439									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.																			
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel										c. LENGTH OF STAY IN 1b transient										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale- Glen Burnie 02X02									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Contee Road										d. STREET ADDRESS 115 Wells Avenue										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Margaret Ann Adams										4. DATE OF DEATH Month March Day 28 Year 19 57																			
5. SEX Female										6. COLOR OR RACE white										7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH Sept. 13, 1939										9. AGE (In years last birthday) 17 yrs.										IF UNDER 1 YEAR Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer										10b. KIND OF BUSINESS OR INDUSTRY U.S. Civil Service										11. BIRTHPLACE (State or foreign country) Maryland									
12. CITIZEN OF WHAT COUNTRY? U.S.A.										13. FATHER'S NAME Cecil Adams										14. MOTHER'S MAIDEN NAME Clara O'Dell									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No										16. SOCIAL SECURITY NO. Unknown										17. INFORMANT Robert Burns; Same address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 822X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compound, comminuted fracture of skull with laceration of brain. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile which overturned off the highway.																			
20c. TIME OF INJURY Month, Day, Year 9. 30 3-28 19 57 Hour XX p. m.										20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway									
20f. (City or town) Near Laurel, Pr. Geo. Md.										(County) 										(State) 									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																													
ACTUAL SIGNATURE John T. Maloney										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED									
EXAMINER'S NAME (Type) John T. Maloney, M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										March 28, 1957																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF April 1/57										22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery									
22d. LOCATION (City, town, or county) Glen Burnie, Maryland										(State) 																			
23. FUNERAL DIRECTOR'S SIGNATURE T. J. Singleton										ADDRESS Glen Burnie, Md.										24a. REC'D BY REGISTRAR DATE APR 3 1957									
24b. REGISTRAR'S SIGNATURE Mellie Bushong																													

RECEIVED

APR 3 1957

BUREAU V. 2

Investigation in an automobile which overturned on the highway.

Investigation of death.

Continued, concerned fracture of skull with

hemorrhage and shock

Robert Davis; same address

Clara Davis

U.S. Civil Service

Virginia

U.S.A.

female white

Sept. 12, 1952

Arch 28

James George

Virginia

James George

Formerly - 17th Street

Investigation

Investigation

115 Wells Avenue

115 Wells Avenue

James George

James George

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03129

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03191

03200

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Claude Middle Anderson Last				4. DATE OF DEATH Month Mar. Day 30 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 12, 1880	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Hugh Anderson				14. MOTHER'S MAIDEN NAME Elizabeth Walters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) --				16. SOCIAL SECURITY NO. --			
17. INFORMANT Ruth Harrington Niece				Address Same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia & edema. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile Pulmonary emphysema. DUE TO (c) Arteriosclerotic heart disease. INTERVAL BETWEEN ONSET AND DEATH 1 day year year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Beallsville, Md				(County) (State)			
21. I certify that I attended the deceased from March 28th , 19 57 , to March 30th , 19 57 , that I last saw the deceased alive on March 30th , 19 57 , and that death occurred at 12:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4214 Goldokh St DATE SIGNED Dr. T. Bergeman M.D. 4214 Goldokh St Dr. T. Bergeman PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/57		22c. NAME OF CEMETERY OR CREMATORY Monoacy Cemetery		22d. LOCATION (City, town, or county) (State) Beallsville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				ADDRESS F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE APR 2 57	
24b. REGISTRAR'S SIGNATURE W. H. Leach							

BUREAU V. S.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md.</u>				c. LENGTH OF STAY IN 1b <u>30 Days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C. 47X-3</u>				d. STREET ADDRESS <u>3900 Burns Place S. E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Vincent</u> Last <u>Athey</u>				4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-16-71</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Ernest V. Athey</u>				14. MOTHER'S MAIDEN NAME <u>Georgia (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>578-12-9544</u>		17. INFORMANT <u>Leah Athey (Wife)</u>		Address <u>Same as Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>541.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastro-Intestinal Bleeding</u> (c) <u>Duodenal Ulcer</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/20, 1957</u> , to <u>3/22, 1957</u> , that I last saw the deceased alive on <u>3/22, 1957</u> , and that death occurred at <u>6:25 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John R. Buell</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>402 Main St., Laurel, Md. 3/22/1957</u>			
PHYSICIAN'S NAME (Type) <u>Dr. J. Buell</u> <u>John R. BUELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/26/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers, RIVERSIDE, MD</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 26 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		JAN 24 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF BURIAL		PLACE OF BURIAL		CITY	
MAY 1 1968		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES		MAY 1 1968		MOBILE, ALABAMA		MOBILE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	

BUREAU V. S.

MAR 26 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>29 hrs. 10 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Middle Last <u>Lucille</u> <u>Baker</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>30</u> <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 28, 25</u>	
9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Canidoy Ga.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John B. Bell</u>				14. MOTHER'S MAIDEN NAME <u>Viola Canidoy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edmond Bell</u>		Address <u>1262 100th St NE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive left subarachnoid hemorrhage</u> DUE TO (b) <u>Hypertension cardiac disease</u> DUE TO (c) <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>3/29</u> , 19 <u>57</u> , to <u>3/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>57</u> , and that death occurred at <u>9:15</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John B. Buell</u>				DATE SIGNED <u>4/1/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. John Buell</u>				M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Birmingham AL</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u>				ADDRESS <u>467 N. St. N.W.</u>		24a. REC'D BY REGISTRAR <u>W. H. Beach</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>APR 5 '57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 5 1957

BUREAU V. S.

RECEIVED		APR 5 1957		BUREAU V. S.	
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED					
2. SEX					
3. AGE					
4. DATE OF BIRTH					
5. PLACE OF BIRTH					
6. OCCUPATION					
7. CAUSE OF DEATH					
8. MANNER OF DEATH					
9. SIGNATURE OF DECEASED					
10. SIGNATURE OF WITNESSES					
11. SIGNATURE OF PHYSICIAN					
12. SIGNATURE OF CORONER					
13. SIGNATURE OF JURY					
14. SIGNATURE OF JUDGE					
15. SIGNATURE OF CLERK					
16. SIGNATURE OF NOTARY					
17. SIGNATURE OF SHERIFF					
18. SIGNATURE OF DEPUTY SHERIFF					
19. SIGNATURE OF CONSTABLE					
20. SIGNATURE OF DEPUTY CONSTABLE					
21. SIGNATURE OF TOWNSHIP CLERK					
22. SIGNATURE OF COUNTY CLERK					
23. SIGNATURE OF STATE CLERK					
24. SIGNATURE OF FEDERAL CLERK					
25. SIGNATURE OF MARSHAL					
26. SIGNATURE OF DEPUTY MARSHAL					
27. SIGNATURE OF SHERIFF					
28. SIGNATURE OF DEPUTY SHERIFF					
29. SIGNATURE OF CONSTABLE					
30. SIGNATURE OF DEPUTY CONSTABLE					
31. SIGNATURE OF TOWNSHIP CLERK					
32. SIGNATURE OF COUNTY CLERK					
33. SIGNATURE OF STATE CLERK					
34. SIGNATURE OF FEDERAL CLERK					
35. SIGNATURE OF MARSHAL					
36. SIGNATURE OF DEPUTY MARSHAL					
37. SIGNATURE OF SHERIFF					
38. SIGNATURE OF DEPUTY SHERIFF					
39. SIGNATURE OF CONSTABLE					
40. SIGNATURE OF DEPUTY CONSTABLE					
41. SIGNATURE OF TOWNSHIP CLERK					
42. SIGNATURE OF COUNTY CLERK					
43. SIGNATURE OF STATE CLERK					
44. SIGNATURE OF FEDERAL CLERK					
45. SIGNATURE OF MARSHAL					
46. SIGNATURE OF DEPUTY MARSHAL					
47. SIGNATURE OF SHERIFF					
48. SIGNATURE OF DEPUTY SHERIFF					
49. SIGNATURE OF CONSTABLE					
50. SIGNATURE OF DEPUTY CONSTABLE					
51. SIGNATURE OF TOWNSHIP CLERK					
52. SIGNATURE OF COUNTY CLERK					
53. SIGNATURE OF STATE CLERK					
54. SIGNATURE OF FEDERAL CLERK					
55. SIGNATURE OF MARSHAL					
56. SIGNATURE OF DEPUTY MARSHAL					
57. SIGNATURE OF SHERIFF					
58. SIGNATURE OF DEPUTY SHERIFF					
59. SIGNATURE OF CONSTABLE					
60. SIGNATURE OF DEPUTY CONSTABLE					
61. SIGNATURE OF TOWNSHIP CLERK					
62. SIGNATURE OF COUNTY CLERK					
63. SIGNATURE OF STATE CLERK					
64. SIGNATURE OF FEDERAL CLERK					
65. SIGNATURE OF MARSHAL					
66. SIGNATURE OF DEPUTY MARSHAL					
67. SIGNATURE OF SHERIFF					
68. SIGNATURE OF DEPUTY SHERIFF					
69. SIGNATURE OF CONSTABLE					
70. SIGNATURE OF DEPUTY CONSTABLE					
71. SIGNATURE OF TOWNSHIP CLERK					
72. SIGNATURE OF COUNTY CLERK					
73. SIGNATURE OF STATE CLERK					
74. SIGNATURE OF FEDERAL CLERK					
75. SIGNATURE OF MARSHAL					
76. SIGNATURE OF DEPUTY MARSHAL					
77. SIGNATURE OF SHERIFF					
78. SIGNATURE OF DEPUTY SHERIFF					
79. SIGNATURE OF CONSTABLE					
80. SIGNATURE OF DEPUTY CONSTABLE					
81. SIGNATURE OF TOWNSHIP CLERK					
82. SIGNATURE OF COUNTY CLERK					
83. SIGNATURE OF STATE CLERK					
84. SIGNATURE OF FEDERAL CLERK					
85. SIGNATURE OF MARSHAL					
86. SIGNATURE OF DEPUTY MARSHAL					
87. SIGNATURE OF SHERIFF					
88. SIGNATURE OF DEPUTY SHERIFF					
89. SIGNATURE OF CONSTABLE					
90. SIGNATURE OF DEPUTY CONSTABLE					
91. SIGNATURE OF TOWNSHIP CLERK					
92. SIGNATURE OF COUNTY CLERK					
93. SIGNATURE OF STATE CLERK					
94. SIGNATURE OF FEDERAL CLERK					
95. SIGNATURE OF MARSHAL					
96. SIGNATURE OF DEPUTY MARSHAL					
97. SIGNATURE OF SHERIFF					
98. SIGNATURE OF DEPUTY SHERIFF					
99. SIGNATURE OF CONSTABLE					
100. SIGNATURE OF DEPUTY CONSTABLE					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03203 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03195

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland p. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chenerly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Capital Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rhoda Jane Barefoot		4. DATE OF DEATH March 21 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1892
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Gun Store	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Westbrook Barefoot		14. MOTHER'S MAIDEN NAME Avery Jant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Virginia City same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive heart failure DUE TO (b) Coronary insufficiency DUE TO (c) Cardiovascular renal disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes - Obesity 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED March 21, 1957	
EXAMINER'S NAME (Type) JAMES I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25-57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. N. Chambers to 517-11-11 S.E.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE W. N. Chambers	

MEDICAL CERTIFICATION

1-13 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. E.

MAR 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03204

CERTIFICATE OF DEATH

03196

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Estates</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>3723 Ingalls Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>M.</u> Last <u>Barr</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-1902</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pittsburgh, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Michael Brauer</u>		14. MOTHER'S MAIDEN NAME <u>Rose Kingeson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>578-14-6797</u>	
17. INFORMANT <u>Clyde Barr</u> Husband		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dissecting Aneurysm of Aorta</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>< 1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 5</u> , 19 <u>56</u> , to <u>March 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 7</u> , 19 <u>57</u> , and that death occurred at <u>8:50 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arnold Lear</u> M.D.		ADDRESS (Street, city or town, state) <u>905 Sheridan St Hyattsville Md.</u>	
DATE SIGNED <u>3-9-57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Arnold Lear</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Haley's Funeral Home Inc.</u>		ADDRESS <u>Mt. Rainier Md.</u>	
24a. REC'D BY REGISTRAR <u>Arnold Lear</u>		24b. REGISTRAR'S SIGNATURE <u>Arnold Lear</u>	
DATE <u>March 10 1957</u>			

MEDICAL CERTIFICATION

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

BUREAU V. S.

MAR 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03256

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1,2 FilmG212 3-20-57 et
CERTIFICATE OF DEATH

03197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville c. LENGTH OF STAY IN 1b X2 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6212 Ritchie Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville d. STREET ADDRESS 6212 Ritchie Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth G Bigham		4. DATE OF DEATH Month Day Year March 16 1957								
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1897	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Francis P. Gunning		14. MOTHER'S MAIDEN NAME Mary Riley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No --			16. SOCIAL SECURITY NO. --	17. INFORMANT Thomas L. Bigham Husband	Address 6212 Ritchie Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma uterus 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) --							INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. no 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Jan 1, 1955 , to Mar 16, 1957 , that I last saw the deceased alive on Mar 14, 1957 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE CK Bonnie		M.D. 301-BNE		Wash DC		3/16/57				
PHYSICIAN'S NAME (Type) AK BOWIE										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/1957		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.				
23. FUNERAL DIRECTOR'S SIGNATURE James Ryan, Inc.				ADDRESS 317 Penna. Ave., SE Wash DC		24a. REC'D BY REGISTRAR APR 18 1957		24b. REGISTRAR'S SIGNATURE Carrie Campbell		

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES M. JONES		MAY 18 1957	
AGE		SEX	
35		Male	
RACE		RELIGION	
White		Roman Catholic	
MARRIAGE		EDUCATION	
Married		High School	
OCCUPATION		PLACE OF BIRTH	
Salesman		Maryland	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
DISEASE OR INJURY		PLACE OF DEATH	
Myocardial Infarction		Home	
DATE OF DEATH		TIME OF DEATH	
May 18 1957		10:30 AM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES	
[Signature]		[Signatures]	
DATE OF SIGNATURE		DATE OF SIGNATURE	
May 18 1957		May 18 1957	

BUREAU V. S.

MAR 18 1957

RECEIVED

03257

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pr. Geo's County Court House, Main Street.		e. STREET ADDRESS "Beechwood"-Route #301:	
3. NAME OF DECEASED (Type or print) First Andrew Middle Gwynn Last Bowie		4. DATE OF DEATH Month March Day 27 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1896
9. AGE (In years lost birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Richmond Irving Bowie	
14. MOTHER'S MAIDEN NAME Effie Gwynn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. A. Gwynn Bowie-Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1/2 hr DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 7 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Thrombosis 1950		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2:00 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) no		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1957 , to Mar 27, 1957 , that I last saw the deceased alive on Mar 25, 1957 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 301-B N E DATE SIGNED 3/28/57			
ACTUAL SIGNATURE A K BOWIE		PHYSICIAN'S NAME (Type) A K BOWIE	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/30/57	22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR APR 2 57	
24b. REGISTRAR'S SIGNATURE DeLoach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		COUNTY [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		SEX [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]		RELIGION [Illegible]	
MARITAL STATUS [Illegible]		DATE OF MARRIAGE [Illegible]		PLACE OF MARRIAGE [Illegible]	
NAME OF PHYSICIAN [Illegible]		NAME OF NURSE [Illegible]		NAME OF ATTENDING PHYSICIAN [Illegible]	
NAME OF FUNERAL HOME [Illegible]		NAME OF BURIAL PLACE [Illegible]		NAME OF CEMETERY [Illegible]	
NAME OF INTERVIEWER [Illegible]		NAME OF WITNESS [Illegible]		NAME OF SIGNER [Illegible]	

BUREAU V. S.

APR 2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 03199										
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 19 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Baby girl			First Middle Last Brooks			4. DATE OF DEATH Month March Day 16 Year 19 57				
5. SEX Female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16, 1957		9. AGE (In years last birthday) yrs. 19		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****				10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME David Brooks					14. MOTHER'S MAIDEN NAME Lucille Moore					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (Yes, no, or unknown)			16. SOCIAL SECURITY NO. Hospital Records		17. INFORMANT Address Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema (fetal cause) DUE TO (maternal cause unknown) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE John T. Maloney					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John T. Maloney, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 17, 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Prin			March 17, 1957		Prince Georges General Hospital		Cheverly Md			
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. R...					ADDRESS Adm		24a. RECEIVED BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Abel J...	

207138XV4

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03258

CERTIFICATE OF DEATH

Reg. Dist. No.

03200

1. PLACE OF DEATH a. COUNTY Prince George, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md. b. COUNTY Prince G	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Croom		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Croom, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #111#111#111#		d. STREET ADDRESS Molly Berry Rd.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leander Middle Brooks Last Brooks		4. DATE OF DEATH Month 3 Day 28 Year 1957	
5. SEX M	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 - 11 - 59
9. AGE (In years last birthday) 97 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Henry Brooks		14. MOTHER'S MAIDEN NAME Barbara (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Ruth Pinkney Croom, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Carcinoma of Right Lung - with Metastasis to Liver + Stomach DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1, 1957, to Mar 28, 1957, that I last saw the deceased alive on Mar 27, 1957, and that death occurred at 2:05 P.M. from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE James G. Sasscer M.D.		ADDRESS (Street, city or town, state) Upper Marlboro Md - 3-28-57	
PHYSICIAN'S NAME (Type) James G. Sasscer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-1 - 57	22c. NAME OF CEMETERY OR CREMATORY Brooks Church	22d. LOCATION (City, town, or county) (State) Naylor, Prince Geo Co, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle R. Rollins 4334 Hunt Pl, NE		24a. REC'D BY REGISTRAR DATE APR 2 1957	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White		5. DATE OF DEATH April 4, 1968		6. TIME OF DEATH 10:00 PM	
7. PLACE OF DEATH Room 306, LBJ Library, Washington, D.C.		8. CITY Washington, D.C.		9. STATE District of Columbia		10. COUNTY District of Columbia		11. ZIP CODE 20540		12. MANNER OF DEATH Suicide	
13. CAUSE OF DEATH Suicide by gunshot wound of the chest		14. ICD-9 CODE 276.21		15. PLACE OF BIRTH Jackson, Mississippi		16. DATE OF BIRTH March 10, 1933		17. SEX OF BIRTH Male		18. RACE OF BIRTH White	
19. OCCUPATION Attorney		20. EDUCATION Bachelor's Degree		21. MARITAL STATUS Single		22. RELIGION Methodist		23. SOCIAL SECURITY NUMBER [REDACTED]		24. SIGNATURE OF DECEASED [REDACTED]	
25. SIGNATURE OF PHYSICIAN [REDACTED]		26. SIGNATURE OF CORONER [REDACTED]		27. SIGNATURE OF WITNESS [REDACTED]		28. SIGNATURE OF WITNESS [REDACTED]		29. SIGNATURE OF WITNESS [REDACTED]		30. SIGNATURE OF WITNESS [REDACTED]	

BUREAU V. S.

APR 2 1968

RECEIVED

03206

CERTIFICATE OF DEATH

03201

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George's County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Faermont Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>717- 62nd Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Brown</u> Last <u>Brown</u>			4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1957</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-16-99</u>		9. AGE (In years last birthday) yrs. <u>58</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>None</u>				14. MOTHER'S MAIDEN NAME <u>None</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Clayton</u> Address <u>624 Addison Rd NE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic pyelo-nephritis & Hypertension</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>3</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/2</u> , 19 <u>57</u> , to <u>3-24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/24</u> , 19 <u>57</u> , and that death occurred at <u>1:20 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John R. Buell</u> M.D.							
PHYSICIAN'S NAME (Type) <u>John R. BUELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>3-28-57</u>		<u>Woodlawn</u>		<u>Washington</u>		<u>D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington & Son</u>				ADDRESS <u>467 N. St. N.W. Wash</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 29 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

09-2022-71

10-1-2

BUREAU A. S.

MAR 29 1957

RECEIVED

03259

03202

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges'			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro				c. LENGTH OF STAY IN 1b 55 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sarah Middle Amelia Last Buck				4. DATE OF DEATH Month March Day 17 Year 1957.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2, 1878	
9. AGE (In years last birthday) 78 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Thomas Ball		14. MOTHER'S MAIDEN NAME Annie Frizzell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Harry Buck, Sr. Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 1956, to 17 Mar , 1957, that I last saw the deceased alive on 16 Mar , 1957, and that death occurred at 1:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro, Maryland DATE SIGNED 3/18/57.							
ACTUAL SIGNATURE R B Sasscer				M.D. Upper Marlboro, Maryland			
PHYSICIAN'S NAME (Type) Robert B. Sasscer,				M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/20/57		22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.				24a. REC'D BY REGISTRAR 20 57		24b. REGISTRAR'S SIGNATURE W. J. [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. DATE OF DEATH [REDACTED]</p>		<p>10. PLACE OF DEATH [REDACTED]</p>	
<p>11. SIGNATURE OF DECEASED [REDACTED]</p>		<p>12. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>13. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>14. SIGNATURE OF CORONER [REDACTED]</p>	
<p>15. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>16. SIGNATURE OF CLERK [REDACTED]</p>	

BUREAU V. 2

MAR 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 9 Film 6213 4-3-57 et
03207
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

03203

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>Burgess</u> Last <u>Burgess</u>				4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-9-1896</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>SAVAGE, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>			
13. FATHER'S NAME <u>JOHN BURGESS</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE BALDWIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>RODNEY BALDWIN, LAUREL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>134.3</u> DUE TO <u>incurable due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>monilia infect</u> (c) <u>Pulmonary edema due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 day</u> <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3-16</u> , 19 <u>57</u> , to <u>3-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-20</u> , 19 <u>57</u> , and that death occurred at <u>5:15 AM</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. H. Hagerman</u> M.D.				DATE SIGNED <u>4-14-57</u>			
PHYSICIAN'S NAME (Type) <u>Hagerman</u>				ADDRESS (Street, city or town, state) <u>4714 Galt St</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar 22 1957</u>		<u>GRACE CEMETERY</u>		<u>SAVAGE, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Selby Laurel</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MAR 26 57

03260

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Forestville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2RURAL-Forestville	
c. LENGTH OF STAY IN 1b 56 yrs.		d. STREET ADDRESS Burton's Lane - Post Office Box 193, Rt. #1, Upper Marlboro, Maryland.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Burton's Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Katherine Middle Helen Last Burton		4. DATE OF DEATH Month March Day 28, Year 19 57.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1890
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	

13. FATHER'S NAME Charles Repp		14. MOTHER'S MAIDEN NAME Mary Scheuch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT John Henry Burton		Address Post Office Box 193, Rt. #1, Upper Marlboro, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Cortical Atrophy DUE TO (c) General Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 5 yrs unknown
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----

21. I certify that I attended the deceased from Jan 1, 1956 , to March 28, 1957 , that I last saw the deceased alive on March 26, 1957 , and that death occurred at 7:30 P. M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Paul C. Van Natta	M.D. 5440 Silver Hill Rd., Suitland, Maryland.
PHYSICIAN'S NAME (Type) Paul C. Van Natta, M.D.	DATE SIGNED 3/29/57

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/31/57	22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery	22d. LOCATION (City, town, or county) (State) Forestville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR APR 2 57	24b. REGISTRAR'S SIGNATURE Paul C. Van Natta

BUREAU V. S.

APR 2 1957

RECEIVED

03208

Item 9 FilmG212 3-26-57 et

CERTIFICATE OF DEATH

03205

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Buelah Middle Butler Last Butler				4. DATE OF DEATH Month March Day 11 Year 19 57			
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 - 6 - 1903	9. AGE (In years last birthday) 54 1/2 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Watkins			14. MOTHER'S MAIDEN NAME Lottie Hill				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) e.v.a. 443X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-5 19 57 to 3-11 19 57 , that I last saw the deceased alive on 3-11 19 57 , and that death occurred at 5:45 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE Harold W. Kelley M.D.			ADDRESS (Street, city or town, state) 6124 - 41st Ave Hyattsville			DATE SIGNED 3/11/57	
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-15-57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Carver Memorial		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington + Son ADDRESS 467 N St. N.W.				24a. REC'D BY REGISTRAR Mar 18 57 DATE		24b. REGISTRAR'S SIGNATURE W. J. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 18 1957

BUREAU V. S.

1. NAME OF PARTY (Last, first, middle initial)
2. DATE OF BIRTH (Month, day, year)
3. SEX (Male, Female)
4. RACE (White, Negro, American Indian, Chinese, Japanese, Hawaiian, Other)
5. OCCUPATION (Type of work)
6. ADDRESS (Street, city, state, zip)
7. EDUCATION (Grade completed)
8. MARITAL STATUS (Single, Married, Divorced, Widowed)
9. RELIGION (If any)
10. SIGNATURE (Printed name)
11. SIGNATURE (Handwritten signature)
12. DATE (Month, day, year)

BUREAU V. S.

MAR 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03206

03209

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>50 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Hospital</u>				d. STREET ADDRESS <u>Winnipeg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul</u> First <u>9</u> Middle <u>Campbell</u> Last <u>March</u>				4. DATE OF DEATH Month <u>31</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1, 1909</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Occlusion Rt Coron. artery</u> DUE TO <u>Hypertensive Arteriosclerotic</u> (c) <u>Cardiovascular Renal Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>1 wk.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/21</u> , 19 <u>57</u> to <u>3/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/21</u> , 19 <u>57</u> , and that death occurred at <u>11:50</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John R. Buell</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>John R. Buell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3-24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Queens Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Manassas Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry S. Washburn</u> ADDRESS <u>467 N. Ave</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 26 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		ANATOMICAL SITE		HISTORICAL FACTS		HISTORICAL FACTS		HISTORICAL FACTS		HISTORICAL FACTS	
10:00 PM		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		HEART		DECEASED WAS FOUND BY POLICE		DECEASED WAS FOUND BY POLICE		DECEASED WAS FOUND BY POLICE		DECEASED WAS FOUND BY POLICE	
DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY	
POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE	
DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY	
POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE	
DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY		DECEASED WAS FOUND BY	
POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE		POLICE	

BUREAU V. 8

MAR 26 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03191

CERTIFICATE OF DEATH

Reg. Dist. No.

0320745

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5801-42nd Ave.</u>				d. STREET ADDRESS <u>3133-Newton St. N.E.</u>			
3. NAME OF DECEASED (Type or print) <u>LEETA MAY COLLINS</u>				4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1904</u>	9. AGE (In years lost birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Joseph Parrish</u>			
14. MOTHER'S MAIDEN NAME <u>Grace ?</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Lowin L. Collins</u> Address <u>3133-Newton St. N.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Uterus & 174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary & Osseous Metastases</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>MAR 23</u> , 19 <u>57</u> , to <u>MAR 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAR. 24</u> , 19 <u>57</u> , and that death occurred at <u>2 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arnold A. Lear</u>				ADDRESS (Street, city or town, state) <u>905 Sheridan St. Hyattsville Maryland</u>			
DATE SIGNED <u>3-26-57</u>				M.D. <u>905 Sheridan St.</u>			
PHYSICIAN'S NAME (Type) <u>ARNOLD A. LEAR</u>				DATE SIGNED <u>3-26-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber L.</u>				ADDRESS <u>517-11th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>James Leroy</u>	
DATE <u>27 1957</u>				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		MARRIAGE [Faint text]		DATE OF DEATH [Faint text]	
AGE [Faint text]		SEX [Faint text]		RACE [Faint text]	
BIRTH DATE [Faint text]		BIRTH PLACE [Faint text]		EDUCATION [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		DATE OF BURIAL [Faint text]		PLACE OF BURIAL [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	

BUREAU V. S.

MAR 27 1957

RECEIVED

03261

CERTIFICATE OF DEATH

Reg. Dist. No.

730

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Pr Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berwyn Hts</u>				c. LENGTH OF STAY IN 1b <u>11 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>same</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8514 - Cunningham Drive</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROSIE</u> First <u>Virginia</u> Middle <u>COLLINS</u> Last				4. DATE OF DEATH <u>MAR</u> Month <u>9</u> Day <u>57</u> Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 4, 1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Fairfax County, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Tobin</u>				14. MOTHER'S MAIDEN NAME <u>Laura Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Thomas T. Collins, Dr., Berwyn Hgt. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Acute Pulmonary Edema</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure, chronic</u> DUE TO <u>(OVER)</u>				<u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Laceration forehead from fall</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>9049</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 1953</u> , 19___, to <u>Feb 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 20</u> , 19 <u>57</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D. <u>4712 - Berwyn Dr</u>				DATE SIGNED <u>College Park, Md</u>			
22a. BURIAL, CREMATION, OR OTHER DISPOSITION <u>Burial</u>		22b. DATE THEREOF <u>3/13/57</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO., Riverdale, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>MAR 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John D. Smith</u>	

County
Police &
Medical
Examined
10 am

notified
3/9/57

jurisdiction waived
W. F.
3/9/57

RECEIVED

MAR 13 1957

BUREAU V. 1

CERTIFICATE OF DEATH

WYOMING CIVIL DEPARTMENT OF HEALTH - BUTTE 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George General MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Hyattsville Md.	
c. LENGTH OF STAY IN 1b 10 Days		d. STREET ADDRESS 4702 41st. Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mashack Middle Conway Last		4. DATE OF DEATH Month Mar. Day 8 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-82
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Murkirk, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Mashack Conway		14. MOTHER'S MAIDEN NAME Caroline ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Carrie Conway (Wife)		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/27/ 19 57 to 3/8/ 19 57 , that I last saw the deceased alive on 3/8/ 19 57 , and that death occurred at 10:40 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Dr. Kelley		M.D. 6124-41st Ave. Hyattsville, Md	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/12/57	22c. NAME OF CEMETERY OR CREMATORY Murkirk Meth. Ceme.	22d. LOCATION (City, town, or county) (State) Murkirk, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John S. Stewart		ADDRESS 30 H Street, N.E.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE W. H. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH OR 18

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Male/Female]</p>		<p>3. AGE [Age]</p>		<p>4. DATE OF BIRTH [Date of birth]</p>		<p>5. PLACE OF BIRTH [Place of birth]</p>	
<p>6. DATE OF DEATH [Date of death]</p>		<p>7. TIME OF DEATH [Time of death]</p>		<p>8. PLACE OF DEATH [Place of death]</p>		<p>9. CAUSE OF DEATH [Cause of death]</p>		<p>10. MANNER OF DEATH [Manner of death]</p>	
<p>11. SIGNATURE OF DECEASED [Signature]</p>		<p>12. SIGNATURE OF WITNESS [Signature]</p>		<p>13. SIGNATURE OF DECEASED [Signature]</p>		<p>14. SIGNATURE OF WITNESS [Signature]</p>		<p>15. SIGNATURE OF DECEASED [Signature]</p>	
<p>16. SIGNATURE OF WITNESS [Signature]</p>		<p>17. SIGNATURE OF DECEASED [Signature]</p>		<p>18. SIGNATURE OF WITNESS [Signature]</p>		<p>19. SIGNATURE OF DECEASED [Signature]</p>		<p>20. SIGNATURE OF WITNESS [Signature]</p>	

BUREAU V. A.

MAR 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03210

03211

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRISON Middle W. Last COOMBS				4. DATE OF DEATH Month MARCH Day 1 Year 1957			
5. SEX M		6. COLOR OR RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-26-89	
9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RE Retired				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Coombs				14. MOTHER'S MAIDEN NAME Mary Waters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Anna Coombs - wife				Address 6135 St. Barnabas rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 331x Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/23 , 1957, to 3-1 , 1957, that I last saw the deceased alive on 3-1 , 1957, and that death occurred at 9:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6124-41st Ave. Hyattsville Md DATE SIGNED 3/1/57							
ACTUAL SIGNATURE Golden W. Kelley M.D.				PHYSICIAN'S NAME (Type) Golden W. Kelley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Wesley S. Pope				ADDRESS 414 15th S.E. D.C.		24a. REC'D BY REGISTRAR DATE MAR 5 '57	
24b. REGISTRAR'S SIGNATURE Wesley S. Pope							

MAR 5 1957

BUREAU V. S.

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03211

03262

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY PRINCE GEORGE		MARYLAND		STATE MARYLAND		COUNTY PRINCE GEO.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SEAT PLEASANT		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SEAT PLEASANT		STREET ADDRESS (If rural give location) 7020 CENTRAL AVE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 720 CENTRAL AVE				STREET ADDRESS 7020 CENTRAL AVE			
3. NAME OF DECEASED (First) (Middle) (Last) SHERWOOD FRANCIS COX				4. DATE OF DEATH (Month) (Day) (Year) 3-8-1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH APRIL 2-1913	
9. AGE last birthday 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SHERWOOD COX				14. MOTHER'S MAIDEN NAME MARY E. PHILLIPS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. 579-01-2031		17. INFORMANT & ADDRESS LUCY V. COX (WIFE) 7020 CENTRAL AVE SEAT PLEASANT	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2-3 hours	
443X IMMEDIATE CAUSE (A) Cerebral Vascular accident -						SEVERAL HOURS	
ANTECEDENT CAUSE(S) DUE TO Hypertensive Cardio-Vascular disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1955, to 3/8 1957, that I last saw the deceased alive on 3/1 1957, and that death occurred at 3 p.m., from the causes and on the date stated above.							
SIGNATURE Max M. Herzberg				ADDRESS (Street, city, town, state) 7016-Prep St., Seat Pleasant, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-13-57		NAME OF CEMETERY OR CREMATORY Washington Natl. Cem. Suitland Maryland		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR DATE MAR 13 1957		REGISTRAR'S SIGNATURE Carrie Campbell		25. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO.		ADDRESS 517 HUBBARD ST. SE	

CERTIFICATE OF DEATH

MD-001-30

1. DECEASED PERSON'S NAME - LAST, FIRST, MIDDLE

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JAILER

21. SIGNATURE OF WARDEN

22. SIGNATURE OF CHIEF OF POLICE

23. SIGNATURE OF DEPUTY CHIEF OF POLICE

24. SIGNATURE OF SQUAD LEADER

25. SIGNATURE OF OFFICER

26. SIGNATURE OF DETECTIVE

27. SIGNATURE OF PATROLMAN

28. SIGNATURE OF TRAFFIC OFFICER

29. SIGNATURE OF INVESTIGATOR

30. SIGNATURE OF ANALYST

31. SIGNATURE OF CHEMIST

32. SIGNATURE OF PATHOLOGIST

33. SIGNATURE OF RADIOLOGIST

34. SIGNATURE OF CLINICAL PATHOLOGIST

35. SIGNATURE OF LABORATORY ASSISTANT

36. SIGNATURE OF RECORDS CLERK

37. SIGNATURE OF FILE CLERK

38. SIGNATURE OF RECEPTIONIST

39. SIGNATURE OF TELEPHONE OPERATOR

40. SIGNATURE OF MAIL CLERK

41. SIGNATURE OF JANITOR

42. SIGNATURE OF GARDENER

43. SIGNATURE OF COOK

44. SIGNATURE OF CLEANER

BUREAU V. S.

MAR 13 1957

RECEIVED

INSTRUCTIONS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A1SME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
03212					03212					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					Reg. Dist. No.					
Block 22 Film G213 4-3-57 et										
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Duckettsville				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS Duckettstown					
3. NAME OF DECEASED (Type or print) First George Middle Greenleaf Last Craig					4. DATE OF DEATH Month March Day 24 Year 19 57					
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1906		9. AGE (In years last birthday) 51 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Craig					14. MOTHER'S MAIDEN NAME Hattie Gross					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT James Edw. Craig; Vista, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Stab wound of chest DUE TO (c) Incised wound of pulmonary artery.										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stab wound of chest caused by another individual.							
20c. TIME OF INJURY Month, Day, Year Hour 11:30 p. m. 3-24-57			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hotel		20f. (City or town) Bowie		(County) Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED March 25, 1957										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 3-29-57		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Church Cem.			22d. LOCATION (City, town, or county) Bowie Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. N. Horton</i> ADDRESS Co. 1322 4. St. NW					24a. RECORD REGISTRY March 27 1957		24b. REGISTRAR'S SIGNATURE <i>W. E. F. Smith</i>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		March 27, 1967	
Place of Birth		Occupation		Cause of Death		Manner of Death	
Baltimore, Maryland		Teacher		Heart Disease		Natural	
Date of Birth		Date of Admission to Hospital		Date of Discharge		Date of Death	
March 20, 1967		March 25, 1967		March 26, 1967		March 27, 1967	
Place of Death		Physician's Name		Physician's Address		Physician's Phone	
Home		Dr. J. A. Smith		123 Main St.		555-1234	
Time of Death		Time of Examination		Time of Autopsy		Time of Burial	
10:00 AM		11:00 AM		12:00 PM		1:00 PM	
Place of Burial		Name of Burial Place		Name of Minister		Name of Officiant	
St. John's Church		St. John's Church		Rev. J. A. Smith		Rev. J. A. Smith	
Name of Undertaker		Name of Funeral Home		Name of Cemetery		Name of Grave	
John Doe		John Doe		St. John's Church		St. John's Church	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
 MAR 27 1967
 BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03213

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03213

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 15 min.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vista- Lanham,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paula Middle Francine Last Craig				4. DATE OF DEATH Month March Day 24, Year 19 57			
5. SEX Female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1955	
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months 22 Days Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Leroy Craig				14. MOTHER'S MAIDEN NAME Florence King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mother; same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491x DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 24, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-27-57		22c. NAME OF CEMETERY OR CREMATORY First Baptist Cem.		22d. LOCATION (City, town, or county) (State) Wheaton, Md	
23. FUNERAL DIRECTOR'S SIGNATURE R. M. Horton Co.				ADDRESS 1322 24 St. NW.		24a. REC'D BY REGISTRAR DATE MAR 27 57. Outkovich	
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATEMENT OF HEALTH - BATHORE 13 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		1957	
Place of Birth		Occupation		Cause of Death		Manner of Death	
New York City		Teacher		Heart Disease		Natural	
Date of Admission		Date of Discharge		Date of Death		Time of Death	
1957		1957		1957		1957	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

MAR 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

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MEDICAL CERTIFICATION

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03214

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro X/			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Louise Last Curtis				4. DATE OF DEATH Month March Day 29 Year 1957			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 Nov. 1951		9. AGE (In years last birthday) 5 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School (Grade)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Curtis				14. MOTHER'S MAIDEN NAME Emma Tony			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas Curtis Address Same as # 2 (Father)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia and exhaustion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 80% First, second and third degree burns of the body DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Clothes caught on fire from a stove in the home					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3/13/ 1957 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Upper Marlboro P. G. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.				ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR APR 2 57	
				24b. REGISTRAR'S SIGNATURE Dr. H. Smith			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
Thomas Curtis		Male		35		Nov. 1921	
Place of Birth		Usual Residence		Place of Death		Cause of Death	
England		Boston, Mass.		General Hospital		Disease	
Occupation		Education		Manner of Death		Signature of Examiner	
School		High School		Natural		[Signature]	
Marital Status		Date of Marriage		Date of Death		Time of Death	
Single		None		Nov. 1957		10:00 AM	
Previous Illnesses		Alcohol Consumption		Toxicology		Autopsy	
None		None		None		None	
Remarks: Found dead in bed, no signs of life.							

RECEIVED
 APR 2 1957
 BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03192
CERTIFICATE OF DEATH

03216
245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Nursing Home				d. STREET ADDRESS 216 N. Culver St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna Margaret Davis				4. DATE OF DEATH Month March Day 1 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1864		9. AGE (In years last birthday) yrs. 92	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Saffron				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Marie Clarius, 216 N. Culver St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC CARDIOVASCULAR-RENAL DISEASE ? YEARS DUE TO (c) ADVANCED ARTERIOSCLEROSIS ? YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 MONTH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/27 , 1957, to 3/1 , 1957, that I last saw the deceased alive on 3/1 , 1957, and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Louis Mendel				ADDRESS (Street, city or town, state) 1506 COLLEGE AVE		DATE SIGNED 3/1/57	
PHYSICIAN'S NAME (Type) C. LOUIS MENDEL				COLLEGE PARK MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR DATE 3/6/57		24b. REGISTRAR'S SIGNATURE James E. Searey	

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03263 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14579 East Avenue				d. STREET ADDRESS 14579 East Avenue					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Joseph Middle Marco Last DeCesaris				4. DATE OF DEATH Month March Day 5 Year 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 17, 1954			
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		IF UNDER 24 HRS. Hours 2 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - CHILD				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.			
12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME Geaton DeCesaris				14. MOTHER'S MAIDEN NAME Elizabeth Procopio					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Marco DeCesaris Address Mitchellville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X (c) 491X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/7/1957		22c. NAME OF CEMETERY OR CREMATORY St. John's			
22d. LOCATION (City, town, or county) (State) Suitland									
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Carreras Co - 517-119 St SE WASH				24a. REC'D BY REGISTRAR March 7, 1957		24b. REGISTRAR'S SIGNATURE Carrie Campbell			

MAR 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, exemption, or removal.

VS. A15ME(5)
SM 9/55

800

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03218
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN 1b Dead on arrival					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights x 2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS 817 52nd Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Miichael Wade Dennis					4. DATE OF DEATH Month March Day 22 Year 30 19 57					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1957		9. AGE (In years last birthday) yrs. 21 Months 21 Hours 19 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Oscar Wade Dennis					14. MOTHER'S MAIDEN NAME Clara Lucille Clark					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs C. L. Clark, same as # 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Suffocation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 9240 (c)										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Over laying of parents						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3/30 1957 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Capital Heights P. G. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE James I. Royd					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED March 30, 1957
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 4-2-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill			22d. LOCATION (City, town, or county) (State) Suitland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lees Sons Co.						ADDRESS 300 4th St N.E. D.C.		24a. REC'D BY REGISTRAR DATE APR 2 1957		24b. REGISTRAR'S SIGNATURE Aut. mail

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Doe	
Sex		Male	
Age		35	
Race		White	
Date of Birth		March 1, 1922	
Place of Birth		Baltimore, Md.	
Usual Residence		123 Main Street, Baltimore, Md.	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Examiner		[Signature]	
Date		April 2, 1957	

BUREAU V. S.

APR 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03219

V39

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b adm 9-2-56 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON 83 x -3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel Sanitarium		d. STREET ADDRESS 814 Oakland Street	
3. NAME OF DECEASED (Type or print) First BETTYE Middle B. Last DORNEY		4. DATE OF DEATH Month 3 Day 25 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13, 1861
9. AGE (In years lost birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Annapolis Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME BENJAMIN FRANKLIN CADELL		14. MOTHER'S MAIDEN NAME EMELINE LEE TIMMONS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT HOSPITAL RECORDS		Address Laurel Sanitarium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardio-vascular disease many years DUE TO (c) (with psychotic reaction)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic brain syndrome associated with cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-2- , 19 56 , to 3-25 , 19 57 , that I last saw the deceased alive on 3-25- , 19 57 , and that death occurred at 5:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE ERIKA P. KRAEMER		ADDRESS (Street, city or town, state) Laurel Sanitarium 3-25-57	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		DATE SIGNED Laurel Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/57	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - Radio 17 Md		24a. REC'D BY REGISTRAR DATE 3/28/57	
24b. REGISTRAR'S SIGNATURE Millie Brashear			

CERTIFICATE OF DEATH

BUREAU V. 2

MAR 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03217

03220

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1614 Chilton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Drevo Last				4. DATE OF DEATH Month March Day 8 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 29, 1880		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cabinet maker		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Drevo				14. MOTHER'S MAIDEN NAME Marie Matousek			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Anna Novotny; 6301 Sheridan St, Riverdale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 8, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/57		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc. 2001-3-5 E. Madison St.				24a. REC'D BY REGISTRAR MAR 12 '57		24b. REGISTRAR'S SIGNATURE W. Leach	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Joseph Brown	
Sex		Male	
Race		White	
Date of Birth		October 22, 1880	
Place of Birth		Greece, Greece	
Occupation		Noted Cabinet Maker	
Residence		1011 Graham St., Baltimore, Md.	
Cause of Death		Acute coronary heart failure	
Manner of Death		Natural	
Signature of Examiner		John T. M. Jones, M.D.	

RECEIVED
 MAR 12 1957
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03218

CERTIFICATE OF DEATH

03221

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TRIN</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Upper Marlboro</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GEN. Hosp</u>			d. STREET ADDRESS <u>Rt #1 - Box 29</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Theron</u> Middle <u>Lake</u> Last <u>Duley</u>			4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13, Sept. 10, 1900</u>		9. AGE (In years last birthday) <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Roads Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Lake Elmore Duley</u>			14. MOTHER'S MAIDEN NAME <u>Mary E. Ellis</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Rt. #1, Box 29</u> <u>Mrs. Sarah Catherine Duley-Upper Marlboro</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X</u> <u>Coronary Thrombosis</u> DUE TO <u>uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Chronic Glomerulonephritis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>3 days</u> <u>10 years</u> <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 17, 1957</u> , to <u>MARCH 19, 1957</u> , that I last saw the deceased alive on <u>MARCH 19, 1957</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Norman Donat Comeru</u>		ADDRESS (Street, city or town, state) <u>3503 Penny St</u>		DATE SIGNED <u>3/19/57</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMERU</u>		<u>MT RAINIER MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cheltenham Methodist Cem.</u>	
				22d. LOCATION (City, town, or county) (State) <u>Cheltenham, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>			24a. REC'D BY REGISTRAR <u>3/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>West</u>

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03265

CERTIFICATE OF DEATH

Reg. Dist. No.

03223
248

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Island Memorial</u>		d. STREET ADDRESS <u>1 4812 Eris Kine Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>A.</u> Last <u>Dwiggins</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>7-21-1880</u>	9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Va.</u>
13. FATHER'S NAME <u>Henry B. Utz</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Catherine Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Husband-Chas. W. Dwiggins</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>acute coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart dis</u> (c) <u>1 year.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr</u> , 19 <u>45</u> , to <u>Mar 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 19</u> , 19 <u>57</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. W. Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Riverdale</u> DATE SIGNED <u>3-19-57</u>	
PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Sachs's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 26 1957</u> 24b. REGISTRAR'S SIGNATURE <u>James Seeger</u>	

alive on radial location

2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 26

BUREAU VS

MAR 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03261 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03222
134

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek		c. LENGTH OF STAY IN 1b 8 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Accokeek			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 25 Manning Road				d. STREET ADDRESS 1 25 Manning Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Roy Last Dunn				4. DATE OF DEATH Month March Day 7 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 6, 1917	9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Dunn				14. MOTHER'S MAIDEN NAME Elsie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 1935-1938		17. INFORMANT Mrs Cornie Dunn same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) Shot gun wound of the head (c), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head with a shot gun					
20c. TIME OF INJURY Hour 4:30 p. m. XXX 3/7 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Accokeek P. G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				DATE SIGNED March 8, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md				24a. RECORDING OFFICIAL'S SIGNATURE MAR 12 1957		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAR 12 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle C. Last Erthal		4. DATE OF DEATH Month 3- Day 14 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-27-94
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Stationery	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Carl Phillip Erthal		14. MOTHER'S MAIDEN NAME Frances Wagner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W W 1		16. SOCIAL SECURITY NO. 579 01 037	
17. INFORMANT Nolia I Erthal		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis & myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerotic Heart Disease DUE TO (c) Arterio sclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1957 to Mar 14, 1957 that I last saw the deceased alive on Mar 14, 1957 and that death occurred at 6:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Wolcott Etienne		ADDRESS (Street, city or town, state) 4713 - Harwyn Rd College Park, Md.	
PHYSICIAN'S NAME (Type) Dr. Wolcott Etienne		DATE SIGNED Mar 21 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/18/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24. REC'D BY REGISTRAR Mar 21 57	
24b. REGISTRAR'S SIGNATURE W. E. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03266

CERTIFICATE OF DEATH

03225

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLENN DALE</u>				c. LENGTH OF STAY IN 1b <u>16 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>GLENN DALE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE L. FERRER</u>				4. DATE OF DEATH Month Day Year <u>MARCH 2 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4.12.1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAPTOMETER OPERATOR EMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>SYRACUSE N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>HENRY FERRER</u>		14. MOTHER'S MAIDEN NAME <u>MARY MC.CORMICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-05-1542</u>		17. INFORMANT Address <u>DECEASED</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.0</u> DUE TO <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE AND COR PULMONALE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DISEASE AND COR PULMONALE</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EMPHYSEMA</u> <u>PULMONARY TUBERCULOSIS MOD. ADVANCED</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2.15</u> , 19 <u>57</u> , to <u>3.2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3.2</u> , 19 <u>57</u> , and that death occurred at <u>8:45</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>MOE WEISS</u> <u>GLENN DALE HOSPITAL MD. 3.3.57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>MOE WEISS</u> <u>GLENN DALE, MARYLAND</u>							
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>March 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON, D. C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>T. F. Costello</u>				ADDRESS <u>1722 NORTH CAPITOL ST. WASH. D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>3/3/57</u>	
24b. REGISTRAR'S SIGNATURE <u>A. J. Hedrick</u>							

MAR 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03226

03193

CERTIFICATE OF DEATH

Reg. Dist. No. *nks*

1. PLACE OF DEATH- COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md COUNTY Prince George	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Hyattsville, Md		CITY (If outside corporate limits, write RURAL and give nearest town) OR Hyattsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS SACRED HEART HOME		STREET ADDRESS (If rural, give location) 5805 Queens Chapel Rd	
3. NAME OF DECEASED (Type or Print) Elizabeth Mary Fitzsimmons		4. DATE OF DEATH (Month) March (Day) 21 (Year) 1957	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single	8. DATE OF BIRTH Feb. ? 1872
9. AGE last birthday 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Fitzsimmons		14. MOTHER'S MAIDEN NAME Mary Reynolds	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mr. Carroll F. Fitzsimmons 100 St. Paul St.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

420.0
Immediate cause

(a) (1) Congestive heart failure

2 days

Antecedent cause(s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b) Arteriosclerotic heart disease

9 yrs.

(c) Lymphosarcoma

1 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 12, 1948, to Mar., 1957, that I last saw the deceased alive on Mar. 20, 1957, and that death occurred at 11:40 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF March 23, 1957	NAME OF CEMETERY OR CREMATORY Cathedral	LOCATION (City, town, or county) Baltimore, Md.	(State)
DATE REC'D BY LOCAL REG. 3-22-57	REGISTRAR'S SIGNATURE James Severick	24. FUNERAL DIRECTOR H. W. Meador, Jr.	ADDRESS 1857 Belmont St.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

MAR 27 1957

RECEIVED
BUREAU

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES H. HARRIS		45		M		W		1882		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
MARCH 29, 1957		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MARCH 29, 1957		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS		GRANDPARENTS	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		2		2		2		2	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
MARCH 29, 1957		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MARCH 29, 1957		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

BUREAU V. S.

MAR 29 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03188
CERTIFICATE OF DEATH

03228

Reg. Dist. No.

130

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4713 Greenwood Rd</u>				d. STREET ADDRESS <u>01-02-2</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>ALBERT</u> Last <u>FULLER</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 25, 1874</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transport.</u>		11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel Fuller</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-09-3540</u>		17. INFORMANT <u>W. Fuller</u>		Address <u>same #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas</u> <u>157x</u> DUE TO <u>metastases to liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Neither</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>Dec 11</u> , 19 <u>56</u> , to <u>Mar</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-4-57</u> , 19 <u>57</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.C. Etienne</u>				M.D. <u>4713 Greenwood Rd</u>			
PHYSICIAN'S NAME (Type) <u>W.C. ETIENNE</u>				DATE SIGNED <u>3-15-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Sachs sons Hyattsville Md</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u>John Smith</u>	

BUREAU V. S.

MAR 15 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>7 hrs - 10 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jessie Furrow</u>		4. DATE OF DEATH <u>March 20 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 17 1882</u>
9. AGE (In years last birthday) <u>74 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife own home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dallas, Texas</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Cerebral vascular accident</u> DUE TO <u>(Cerebral)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiac vascular disease</u> DUE TO (c) <u>several years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>64</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 20</u> , 19 <u>57</u> , to <u>March 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 20</u> , 19 <u>57</u> , and that death occurred at <u>1:50</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>T. J. Boegeman</u>		DATE SIGNED <u>4314 Jellison St</u>	
PHYSICIAN'S NAME (Type) <u>Dr. T. J. Boegeman</u>		<u>Hyemorth</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Adair Hill</u>	22d. LOCATION (City, town, or county) <u>Switzland, Md. (Prince Georges)</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u>		ADDRESS <u>2nd Rainier, Md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Q. L. Smith</u>	
DATE <u>MAR 28 57</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Page First

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1912</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>	
9. PLACE OF DEATH <i>Home</i>		10. TIME OF DEATH <i>10:30 AM</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>	
15. SIGNATURE OF FUNERAL HOME <i>John Doe</i>		16. SIGNATURE OF BURIAL PLACE <i>John Doe</i>	
17. SIGNATURE OF CEMETERY <i>John Doe</i>		18. SIGNATURE OF INTERMENT <i>John Doe</i>	
19. SIGNATURE OF INTERMENT <i>John Doe</i>		20. SIGNATURE OF INTERMENT <i>John Doe</i>	
21. SIGNATURE OF INTERMENT <i>John Doe</i>		22. SIGNATURE OF INTERMENT <i>John Doe</i>	
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51. SIGNATURE OF INTERMENT <i>John Doe</i>		52. SIGNATURE OF INTERMENT <i>John Doe</i>	
53. SIGNATURE OF INTERMENT <i>John Doe</i>		54. SIGNATURE OF INTERMENT <i>John Doe</i>	
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67. SIGNATURE OF INTERMENT <i>John Doe</i>		68. SIGNATURE OF INTERMENT <i>John Doe</i>	
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91. SIGNATURE OF INTERMENT <i>John Doe</i>		92. SIGNATURE OF INTERMENT <i>John Doe</i>	
93. SIGNATURE OF INTERMENT <i>John Doe</i>		94. SIGNATURE OF INTERMENT <i>John Doe</i>	
95. SIGNATURE OF INTERMENT <i>John Doe</i>		96. SIGNATURE OF INTERMENT <i>John Doe</i>	
97. SIGNATURE OF INTERMENT <i>John Doe</i>		98. SIGNATURE OF INTERMENT <i>John Doe</i>	
99. SIGNATURE OF INTERMENT <i>John Doe</i>		100. SIGNATURE OF INTERMENT <i>John Doe</i>	

BUREAU V. F.

MAR 26 1957

RECEIVED

Reg. Dist. No.

234

M

I

MEDICAL CERTIFICATION

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Arbutus Lane		d. STREET ADDRESS 1 Arbutus Lane	
3. NAME OF DECEASED (Type or print) EUGENE First E. Middle GARGES Last		4. DATE OF DEATH Month MARCH Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 24, 1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) WASH. D. C.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME JOHN H. GARGES		14. MOTHER'S MAIDEN NAME ISABELLE LEE MAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 526-36-9087	
17. INFORMANT Florrie E. Garga		Address Clinton Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 526X Nutritional failure & edema DUE TO Bronchiectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Emphysema + unknown lung path DUE TO (b) 1 1/2 yrs (c) 14 yrs		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs 14 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 2, 1943 , to Mar 29, 1957 , that I last saw the deceased alive on Mar 18, 1957 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. R. Fenton		ADDRESS (Street, city or town, state) 1801 E St NW, Wash DC	
DATE SIGNED APR 2 '57		24b. REGISTRAR'S SIGNATURE Charles Campbell	
22a. BURIAL CREMATION, REMOVAL, etc. Buried		22b. DATE THEREOF 4-2-57	
22c. NAME OF CEMETERY OR CREMATORY Congressional		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee Son		ADDRESS WASH. D. C.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Place of death

Age

Place of death

City

City

Place of death

Place of death

X

MARCH 22

CHARGES

E. CHARGES

OCT 24 1898

White male

WASH. D.C.

Isabelle LEWIS

John H. Garber

225-36-9070 - Florence E. Garber - Clinton, Mass.

No

BUREAU V. S.

APR 2 1957

RECEIVED

Signature

J. W. Thompson - Wash. D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03231

03221

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 10 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Garilli Last Garilli				4. DATE OF DEATH Month 3 Day 14 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-10-77	
9. AGE (In years last birthday) 79 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tile Setter		10b. KIND OF BUSINESS OR INDUSTRY Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Pietro Garilli				14. MOTHER'S MAIDEN NAME Cecilia Mazzocchi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ?		17. INFORMANT Michael L. Garilli Address Mt. Rainier 3508-Shepherd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lobar Pneumonia - Rt. Upper Lobe							INTERVAL BETWEEN ONSET AND DEATH 5 mins
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Mar. 1 , 19 57 , to Mar. 14 , 19 57 , that I last saw the deceased alive on Mar. 14 , 19 57 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3308 Perry St., Mt. Rainier, Md. DATE SIGNED 3/14/57 ACTUAL SIGNATURE Charles C. Hageage M.D. PHYSICIAN'S NAME (Type) Charles C. Hageage M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/18/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland, Prince George's	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home				ADDRESS 3200-R.I. AVE. Mt. Rainier		24a. REC'D BY REGISTRAR MAR 19 57	
24b. REGISTRAR'S SIGNATURE W. L. Smith							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DECEASED NAME LAST FIRST MIDDLE JAMES EARL RAY		SEX MALE		DATE OF BIRTH 10-1-28		PLACE OF BIRTH MOBILE, ALABAMA	
OCCUPATION MEMBER OF CONGRESS		MARITAL STATUS SINGLE		DATE OF DEATH 4-4-68		PLACE OF DEATH MEMPHIS, TENNESSEE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH ACCIDENTAL		TIME OF DEATH 11:57 AM		PLACE OF DEATH ROOM 306, MOTEL BEYONCE	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF JURY (None)		SIGNATURE OF JUDGE (None)	

RECEIVED
 MAR 19 1957
 BUREAU V. 2

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03232

03269

CERTIFICATE OF DEATH

Reg. Dist. No. *nr*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Prince Georges</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR and give nearest town				OR			
TOWN <i>Seat Pleasant</i>		<i>life</i>		TOWN <i>Seat Pleasant</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>6922 F St.</i>				STREET ADDRESS (If rural give location) <i>6922 F St.</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>MARY</i> (Middle) <i>RAWLINGS</i> (Last) <i>GARNER</i>				(Month) <i>MARCH</i> (Day) <i>7</i> (Year) <i>1957</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<i>FEMALE</i>	<i>White</i>	<i>Widowed</i>	<i>MAY 5 1871</i>	<i>85</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>HOUSEWIFE</i>		<i>✓</i>		<i>MARYLAND</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>GEORGE E SMITH</i>				<i>UNKNOWN</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>NO</i>				<i>None</i>		<i>ALBERT C. RAWLINGS, SON</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <i>CEREBRAL HEMORRHAGE</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 WEEKS</i>			
ANTECEDENT CAUSE(S) DUE TO <i>HYPERTENSIVE CARDIO-VASCULAR DISEASE</i>				<i>SEVERAL YEARS</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>2/10</i> , 19 <i>57</i> , to <i>3/7</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>3/2</i> , 19 <i>57</i> , and that death occurred at <i>9:30 P.</i> M., from the causes and on the date stated above.							
SIGNATURE <i>Max M. Hengberg</i>				ADDRESS (Street, city, town, state) <i>7016 - prep st, Seat Pleasant, Md 20786</i>		DATE SIGNED <i>May 30/57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>BURIAL</i>		<i>3-11-1957</i>		<i>Mt. OLIVET</i>		<i>WASHINGTON, D.C.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>MAR 11 1957</i>		<i>Carrie Campbell</i>		<i>W. W. Chambers & Co</i>		<i>Washington, D.C.</i>	

BUREAU V. 5

MAR 11 1957

RECEIVED

729 11

03222
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley		c. LENGTH OF STAY IN 1b 15 Hyattsville Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hosp.		d. STREET ADDRESS 1 3406-63rd. Ave.	
3. NAME OF DECEASED (Type or print) First Ethel Middle Graylor Last		4. DATE OF DEATH Month March Day 5 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-21-08
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk secretary		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Emory E. Graylor		14. MOTHER'S MAIDEN NAME Mabel Litchford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. S. England, Cherry Manor Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.4 Atherosclerotic Arteriosclerosis severe DUE TO (b) Septicemia (bacteremia) DUE TO (c) Thrombotic purpura secondary to (A) & (B)		INTERVAL BETWEEN ONSET AND DEATH 3400	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/3/57 to 3/5/57, that I last saw the deceased alive on 3-4-1957, and that death occurred at 9:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. L. ETIENNE		ADDRESS (Street, city or town, state) 4713-35th Wym Md	
PHYSICIAN'S NAME (Type) W. L. ETIENNE		DATE SIGNED 3-7-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/57	
22c. NAME OF CEMETERY OR CREMATORY St John's Cemetery		22d. LOCATION (City, town, or county) (State) Beltsville, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE MAR 8 '57		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 8 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03234

03270

CERTIFICATE OF DEATH

Items 1, 2 Film G212 3-11-57 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince George</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oxen Hill</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Oxen Hill</u>			
TOWN <u>Rural</u>				TOWN <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6951 Fort Foote Rd S.E.</u>				STREET ADDRESS (If rural give location) <u>6951 Fort Foote Rd S.E.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Edward Ignatius Gibbons</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 2 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 24, 1906</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
							Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Prince George County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Leonard Gibbons</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>578483829</u>		17. INFORMANT & ADDRESS <u>Mrs Pauline Gibbons (same)</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
163X IMMEDIATE CAUSE (A) <u>Tracheal Collapse due to Ca</u>						<u>3 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of Upper Bronchi</u>						<u>7 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>11-20-56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Tracheotomy</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>June 19 56</u> , to <u>March 2, 19 57</u> , that I last saw the deceased alive on <u>March 2, 19 57</u> , and that death occurred at <u>11:55 PM</u> on the causes and on the date stated above.							
SIGNATURE <u>Anno Coyne Todd, M.D.</u>		M.D. <u>7519 Broadview Rd S.E. D.C. 22</u>		DATE SIGNED <u>3/2/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 5-57</u>		NAME OF CEMETERY OR CREMATORY <u>St Ignatius</u>		LOCATION (City, town, or county) (State) <u>Oxen Hill Md</u>	
24. REC'D BY REGISTRAR <u>MAR 5 1957</u>		REGISTRAR'S SIGNATURE <u>A. J. Hedrick</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros. 1661 - 9th Hyatt</u>		ADDRESS <u>2nd St SE</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03271

CERTIFICATE OF DEATH

Reg. Dist. No.

03236
247

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bowie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Priscilla</u> Last <u>Grayson</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23 1903</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Race track</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Mary Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Aliene E. Johnson</u>		Address <u>Bowie, md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 1955, to <u>Mar</u> , 1957, that I last saw the deceased alive on <u>Mar 20</u> , 1957, and that death occurred at <u>7:25 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Henry A. Wise Jr.</u> M.D. <u>149 9th</u>		ADDRESS (Street, city or town, state) <u>Bowie, md.</u>	
DATE SIGNED <u>3/21/57</u>			
PHYSICIAN'S NAME (Type) <u>Henry A. Wise Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/25/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Church of Ascension</u>	22d. LOCATION (City, town, or county) (State) <u>Bowie, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Stewart</u>		ADDRESS <u>30 H Street, N.E.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Agnes Youngling</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 26 1957

MAR 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

03223

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival X / Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Brown Greenleaf		4. DATE OF DEATH Month Day Year March 15 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1931
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY County Roads	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Greenleaf		14. MOTHER'S MAIDEN NAME Annie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Estelle Smith, Upper Marlboro, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of the skull, crushed chest, fracture of the (a), stating the underlying cause last. DUE TO (c) right femur and left humerus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) a fixed object Driver of an automobile that ran off the road and struck/	
20c. TIME OF INJURY Hour Minute Day, Year 7:31 p. m. 3/ 15 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Upper Marlboro P. G. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 16, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/57	
22c. NAME OF CEMETERY OR CREMATORY Upper Marlboro		22d. LOCATION (City, town, or county) (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 2 D B Colme 412-H at NE Washington DC		24a. REC'D BY REGISTRAR DATE MAR 21 '57	
24b. REGISTRAR'S SIGNATURE			

On the other hand, the \mathbb{R}^n is a vector space over \mathbb{R} and \mathbb{C} is a vector space over \mathbb{R} .

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

03224

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Mitchellville					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Lewis Last Hackley				4. DATE OF DEATH Month March Day 9 Year 1957					
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1896		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Hackley				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1 579-16-6612		17. INFORMANT Carrie Hackley; Same address.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease. (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 10, 1957					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Washington Arlington, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 901 3rd St., S. W.				24a. REC'D BY REGISTRAR DATE MAR 13 57		24b. REGISTRAR'S SIGNATURE W. L. Leach			

RECEIVED

MAR 13 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03225

Items 12, 13, 14, Film 0213 4-1-57 et

CERTIFICATE OF DEATH

03239

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) PrinceGeorge General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Willie Middle Hannah Last Hannah				4. DATE OF DEATH Month March Day 26 Year 19 57			
5. SEX Male		6. COLOR Black		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 April 1922	
9. AGE (In years last birthday) yrs. 34		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary vascular disease 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to generalized arteriosclerosis DUE TO (c) gran							INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 22nd, 1957 , to March 26th, 1957 , that I last saw the deceased alive on March 26, 1957 , and that death occurred at 11:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. J. Bergmann M.D.				ADDRESS (Street, city or town, state) 4114 1st St N.W.			
PHYSICIAN'S NAME (Type) John T. Bergmann				DATE SIGNED March 26, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3-26-57		22c. NAME OF CEMETERY OR CREMATORY —		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Bergmann & Co.				ADDRESS 901 3rd St. S.W.		24a. REC'D BY REGISTRAR DATE MAR 29 '57	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

3203

BUREAU V. 2

MAR 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1 Box 263-- Route 1.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Clayton Hatton				4. DATE OF DEATH March 1, 1957			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, '01		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Hatton				14. MOTHER'S MAIDEN NAME Sarah J. Wignall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Helen R. Fowler; same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 1, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 4, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Christ Church Cemetery		22d. LOCATION (City, town, or county) (State) Clinton Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR W. J. Seduck DATE MAR 6 57	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-CARLISLE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
Date of Death		Time of Death		Place of Death		Cause of Death	
Manner of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Report		Time of Report		Place of Report		Cause of Report	
Manner of Report		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	

BUREAU V. 2

MAR 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03227

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03241

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 2109 Queens Chapel Road	
3. NAME OF DECEASED (Type or print) First Edward Middle Bernard Last Hoernig		4. DATE OF DEATH Month March Day 18 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 19, 1886
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired electrician		10b. KIND OF BUSINESS OR INDUSTRY Electrical	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry G. Hoernig		14. MOTHER'S MAIDEN NAME Caroline Kunze	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Irma Marie Mills; same address	
17. INFORMANT Irma Marie Mills; same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED March 18, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md Pr Geo.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		24a. REC'D BY REGISTRAR 3200-R.I.AVE.	
24b. REGISTRAR'S SIGNATURE March 21 '57		24c. REGISTRAR'S SIGNATURE March 21 '57	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Maloney	
Sex		Male	
Age		60.0	
Race		White	
Date of Death		October 12, 1957	
Place of Death		Home	
Cause of Death		Cardiovascular disease	
Manner of Death		Natural	
Signature of Medical Examiner		Caroline Evans	
Signature of Coroner		John T. Maloney	

RECEIVED
 MAR 21 1957
 BUREAU V. 5

CERTIFICATE OF DEATH

Reg. Dist. No.

03228

1. PLACE OF DEATH a. COUNTY Prince Georges E				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Flornnee Hostbjoer				4. DATE OF DEATH Month Day Year March 29 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-93	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Hospital Records, Cheverly, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) Cerebral aneurysm - ruptured						INTERVAL BETWEEN ONSET AND DEATH 2 days years 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) as above						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from March 194 , 19 57 , to March 29 , 19 57 , that I last saw the deceased alive on March 29 , 19 57 , and that death occurred at 7:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 Jellie Rd DATE SIGNED April 26 1957							
ACTUAL SIGNATURE T. H. Bergeman M.D. 4314 Jellie Rd							
PHYSICIAN'S NAME (Type) Dr. Teal Bergeman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-3-57		22c. NAME OF CEMETERY OR CREMATORY FLAXTON, North Dakota		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysongbo				24a. REC'D BY REGISTRAR DATE APR 2 '57		24b. REGISTRAR'S SIGNATURE Reed	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

50-54-3

APR 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12, 13, 14, File G214 4-18-57 et

03229

CERTIFICATE OF DEATH

03243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 hours	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Accokeek			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS Rt. 1 Box 96	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Johnson Last Johnson		4. DATE OF DEATH Month March Day 18 Year 1957	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Dec. 1880
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Accokeek, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Johnson		14. MOTHER'S MAIDEN NAME Sophia Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction due to 420.0 DUE TO arteriosclerotic heart disease - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) pulmonary edema - bilateral DUE TO (c) Hydrothorax -		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/17 , 19 57 to 3/18 , 19 57 , that I last saw the deceased alive on 3/18 , 19 57 , and that death occurred at 6.05 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Til Bergeman		ADDRESS (Street, city or town, state) 4314 Golda St.	
PHYSICIAN'S NAME (Type) Til Bergeman		DATE SIGNED Hyattsville M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-21-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Metropolitan M.E. Church		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Barnes & Matthews		ADDRESS 614 - 7th St.	
24a. REC'D BY REGISTRAR MAR 21 57		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

CERTIFICATE OF DEATH

NAME OF DECEASED George Washington Johnson		DATE OF BIRTH 1880		PLACE OF BIRTH Maryland	
SEX Male		RACE White		EDUCATION High School	
OCCUPATION None		MARRIAGE Married		DATE OF MARRIAGE 1905	
DATE OF DEATH 1957		PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Heart Disease	
IMMEDIATE CAUSE OF DEATH Myocardial Infarction		INTERMEDIATE CAUSE OF DEATH Coronary Artery Disease		UNDERLYING CAUSE OF DEATH Arteriosclerosis	
DATE OF REPORT 1957		PLACE OF REPORT Baltimore, Maryland		REPORTED BY Dr. J. H. Smith	

SIGNATURE OF REPORTER <i>[Signature]</i>		DATE 1957	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		DATE 1957	
SIGNATURE OF CLERK <i>[Signature]</i>		DATE 1957	

BUREAU V. S.

MAR 21 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 10a, 11, 13, 14, Film G212 3-22-57 et
03230
CERTIFICATE OF DEATH

03244

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 1/2 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wash., D. C. 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 303 R St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Corrine Middle Joyner Last				4. DATE OF DEATH Month March Day 16 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 47 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator operator				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 47 yrs.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Rex Alexander Givens				14. MOTHER'S MAIDEN NAME Florence Blackwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary edema & hydrothorax 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) acute coronary occlusion cause (c), stating the underlying cause last. (c) hypertension or arteriosclerosis heart & aorta PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 3 1/2 severe years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 16th, 19 57 , to March 16th, 19 57 , that I last saw the deceased alive on March 16th, 19 57 , and that death occurred at 9:30P M. from the causes and on the date stated above.							
ACTUAL SIGNATURE T. Pic Bergeman				ADDRESS (Street, city or town, state) 4314 Jackson St			
PHYSICIAN'S NAME (Type) Dr. T. Pic Bergeman				DATE SIGNED Hyckthorpe M. O.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/20/57		22c. NAME OF CEMETERY OR CREMATORY LINCOLN Mem		22d. LOCATION (City, town, or county) (State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE James J. ...				24a. REC'D BY REGISTRAR DATE MAR 19 '57		24b. REGISTRAR'S SIGNATURE W. ...	

CERTIFICATE OF DEATH

Place of Birth: [illegible]

Place of Death: [illegible]

Time of Death: [illegible]

Age: [illegible]

Sex: [illegible]

Color: [illegible]

Height: [illegible]

Weight: [illegible]

Education: [illegible]

Occupation: [illegible]

Marital Status: [illegible]

Religion: [illegible]

Place of Birth: [illegible]

Place of Death: [illegible]

Time of Death: [illegible]

Age: [illegible]

Sex: [illegible]

Color: [illegible]

BUREAU V. S.

MAR 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 245

ITEM #21- FILM 212 - 3/26/57-HB

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newisdale 8 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newisdale, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None-6915-24th Ave.		d. STREET ADDRESS 16915-24th Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last VERA MAE JUNTA.		4. DATE OF DEATH Month March Day 16 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/1926
9. AGE (In years less birthday) 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT Home	
11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry M Jett		14. MOTHER'S MAIDEN NAME Blanche Hudlow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-26-966	
17. INFORMANT Philip A Junta		Address 6915-24th Ave Newisdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330x Subarachnoid Hemorrhage DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Probable Cerebral Aneurysm DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5-10 minutes small OCT 23 1955			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 5, 1956, to March 16, 1957, that I last saw the deceased alive on Feb 5, 1957, and that death occurred at 2:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert B. Irey		ADDRESS (Street, city or town, state) 7105 Riggs Rd. Hyattsville M.D. DATE SIGNED 3-16-57	
PHYSICIAN'S NAME (Type) Robert B. Irey			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/57	
22c. NAME OF CEMETERY OR CREMATORY Northwood Cem.		22d. LOCATION (City, town, or county) (State) College Park, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W W Chambers Co. Riverdale Md		24a. REC'D BY REGISTRAR DATE Mar. 22, 1957	
24b. REGISTRAR'S SIGNATURE J. Severe			

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

03231

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03246

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Hillside			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 1 6484 Walker Mill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Henry Last King				4. DATE OF DEATH Month March Day 16 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/19/1879	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Thomas King				14. MOTHER'S MAIDEN NAME Isabelle Dick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Address Margaret King, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 812x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed and fractures of the pelvis DUE TO (c) Fracture of the left ankle						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of the left ankle						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by an automobile					
20c. TIME OF INJURY Hour xxx 9:45 a.m. 3/15 19 57 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 5		20f. (City or town) (County) (State) Oakland P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James I. Boyd</i> EXAMINER'S NAME (Type) James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 16, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-20-57		22c. NAME OF CEMETERY OR CREMATORY Washington Natl.		22d. LOCATION (City, town, or county) (State) Switzland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers</i> ADDRESS 517-11 St. I.E.				24a. REC'D BY REGISTRAR BAR 19 57		24b. REGISTRAR'S SIGNATURE <i>Aut. 1957</i>	

MINISTRY AND STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINERS' CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Signature of Examiner		Signature of Physician		Signature of Coroner	
John Thomas Smith		Male		45		1910		New York City		New York City		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Last Illness		Time of Death		Place of Death		Time of Burial		Place of Burial		Time of Exhumation		Place of Exhumation	
Teacher		High School		Married		None		Heart Failure		1955		New York City		1955		New York City		None		None	
Signature of Deceased		Signature of Next of Kin		Signature of Coroner		Signature of Physician		Signature of Examiner		Signature of Coroner		Signature of Physician		Signature of Examiner		Signature of Coroner		Signature of Physician		Signature of Examiner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAR 19 1957

RECEIVED

03232

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 XXXXXXXX Tuxedo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacarda Rest Home		d. STREET ADDRESS 2303 57th Avenue XXXXXXXXXXXXXXXXXXXX	
3. NAME OF DECEASED (Type or print) First Frank Middle M. Last Kirby Sr		4. DATE OF DEATH Month March Day 9th Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 8th 1891
9. AGE (In years lost birth day) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt	
11. BIRTHPLACE (State or foreign country) Wash, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kirby		14. MOTHER'S MAIDEN NAME Eva Fant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 2303 57th Avenue	
17. INFORMANT Mary Alice Kirby		Tuxedo, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic ht disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) Paralysis of both lower legs - from stroke 10 yrs ago			INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 5 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN , 19 54 , to 9 MAR , 19 57 , that I last saw the deceased alive on 9 Mar , 19 57 , and that death occurred at 12:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3404 CHEVERLY AVE DATE SIGNED ACTUAL SIGNATURE John Kehoe M.D. CHEVERLY MD 3/19/57 PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-12-1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Md
23. FUNERAL DIRECTOR'S SIGNATURE John A Mattingly		24a. REC'D BY REGISTRAR Wash, D.C.	24b. REGISTRAR'S SIGNATURE MAR 12 57

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

03274

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 FilmG213 4-3-57 et

Reg. Dist. No.

234

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tuckers Bridge, Tucker Road		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) First Middle Last John Lawrence Knighton		4. DATE OF DEATH Month Day Year March 16 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/11/97
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph H. Knighton		14. MOTHER'S MAIDEN NAME Mary E. Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs G. M. Moore Richmond Virginia.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823x DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed chest (c) Crushed chest DUE TO (c) Crushed chest PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile that ran off road and struck a bank	
20c. TIME OF INJURY Month, Day, Year 12:20 PM 3/16/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road bridge		20f. (City or town) (County) (State) Oxon Hill P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 16, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/22/57	22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	22d. LOCATION (City, town, or county) (State) Bladensburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR MAR 28 1957 Carrie Campbell	
24b. REGISTRAR'S SIGNATURE			

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death	
John Doe		Male		35		White		March 25, 1957	
Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation	
New York City		New York City		Heart Disease		Natural		Teacher	
Date of Birth		Date of Admission to Hospital		Date of Discharge		Date of Death		Date of Autopsy	
March 10, 1922		March 20, 1957		March 24, 1957		March 25, 1957		March 26, 1957	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Physician		Signature of Nurse	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
MAR 26 1957
BUREAU V. 2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral director's removal of remains. File page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to funeral director's removal of remains.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03273

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03248

Reg. Dist. No.

730

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Iowa b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Lane				d. STREET ADDRESS Geneva 53x-3			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Selbo Ferdinand Kramer				4. DATE OF DEATH Month Day Year March 29, 19 57			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Rudolph Dederick Kramer				14. MOTHER'S MAIDEN NAME Louise			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. 481-48-6420			
17. INFORMANT Marjorie Miller; 7903 Lockney Ave., Hyattsville				Address Takoma Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Fractured skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by an automobile while walking across the highway.			
20c. TIME OF INJURY Month, Day, Year 4.05 P.M. Mar. 29 19 57				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Langley Park- Pr. Geo. Md.				(County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED March 29, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Removal				22b. DATE THEREOF 4/2/57		22c. NAME OF CEMETERY OR CREMATORY Ackley Cemetery	
22d. LOCATION (City, town, or county) Ackley				(State) Iowa			
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR APR 2 1957	
24b. REGISTRAR'S SIGNATURE John A. Smith							

MEDICAL CERTIFICATION

MISSOURI STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John J. Jones	
Sex		Male	
Race		White	
Date of Birth		June 10, 1912	
Place of Birth		Tennessee	
Usual Residence		Tennessee	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	

Death occurred on June 10, 1957, at the residence of the deceased, 1234 Main Street, Nashville, Tennessee. The deceased was 45 years of age, single, and a resident of Nashville, Tennessee. He was employed as a [unclear] for the [unclear] Company. He had no known chronic diseases. He died of a sudden heart attack while working in his office. The autopsy was performed on June 11, 1957, at the [unclear] Hospital. The findings of the autopsy were consistent with the cause of death listed on the certificate. The body was buried on June 12, 1957, at the [unclear] Cemetery.

APR 2 1957

BUREAU V. S.

RECEIVED

03233

CERTIFICATE OF DEATH

03249

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George General MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write rural or give nearest town) Cheverly Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 5719 Forest Road	
3. NAME OF DECEASED (Type or print) Allie E. Lane		4. DATE OF DEATH Month March. Day 18 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-28-03
9. AGE (In years birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research Analyst		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.	
11. BIRTHPLACE (State or foreign country) RICHMOND, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PATRICK LANE		14. MOTHER'S MAIDEN NAME ESSIE CAVANAUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Same	
17. INFORMANT Martha Lee Lane (Wife)		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Posterior Coronary Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 18 hrs. P
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-13-1957 , to 3-13-1957 , that I last saw the deceased alive on 3-13-1957 , and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3503 Perry St. Mt. Rainier Md. DATE SIGNED 3-13-57			
ACTUAL SIGNATURE Waldo B. Moyers M.D. 3503 Perry St. Mt. Rainier Md.			
PHYSICIAN'S NAME (Type) Dr. N. Combs Waldo B. Moyers 3503 Perry St. Mt. Rainier Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-18-57	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY MT. CALVARY Cem.	22d. LOCATION (City, town, or county) (State) RICHMOND VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Linda Haden		24a. REC'D BY REGISTRAR DATE MAR 18 57	24b. REGISTRAR'S SIGNATURE W. Leach

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 18 1957
BUREAU V. S.

BUREAU V. S.

MAR 18 1957

RECEIVED

03234

CERTIFICATE OF DEATH

03250

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md.</u>				c. LENGTH OF STAY IN 1b <u>15 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Lanham</u> Last <u>Lanham</u>				4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-28-95</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lather</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Leonard Frank Lanham</u>		14. MOTHER'S MAIDEN NAME <u>Alma Allison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Harriet Lanham</u> Address <u>408-61st Ave Capitol Hgts Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAE BETWEEN ONSET AND DEATH <u>15 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>15 Mar</u> , 19 <u>57</u> , to <u>March 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 15</u> , 19 <u>57</u> , and that death occurred at <u>10:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainin</u> M.D.				ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>			
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				DATE SIGNED <u>3/15/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Southland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamberlaine Co.</u>				24a. REC'D BY REGISTRAR <u>Wash. D.C.</u>			
24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>				DATE <u>MAR 19 57</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 19 1957

RECEIVED

CERTIFICATE OF DEATH

03235

Reg. Dist. No. 239

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		LENGTH OF STAY (in this place) <u>adm. 1-10-55</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		<u>03552</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel Sanitarium</u>				STREET ADDRESS (If rural give location) <u>629 Round Oak Road.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Ellen</u> (Last) <u>Logan</u>				(Month) <u>3</u> (Day) <u>16</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>5-27-1884</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teachers college</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Luke Logan</u>				14. MOTHER'S MAIDEN NAME <u>Brigit Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Hospital records, Laurel Sanitarium</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>cerebral vascular accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>several hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>chronic brain syndrome associated with</u>						17-8 years ago	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>cerebral arteriosclerosis with psychotic reaction</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 7, 1956</u> , to <u>March 16, 1957</u> , that I last saw the deceased alive on <u>3-16, 1957</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[ERIKA P. KRAEMER]</u> M.D.				ADDRESS (Street, city, town, state) <u>Laurel Sanitarium, Laurel Md.</u> DATE SIGNED <u>3-16-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar 19, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>St Joseph Cemetery</u>		LOCATION (City, town, or county) (State) <u>Texas, Balto. Co. Md</u>	
24. REC'D BY REGISTRAR <u>MAR 18 1957</u>		REGISTRAR'S SIGNATURE <u>Mildie Brashers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co</u>		ADDRESS <u>4905 York Rd</u>	

INSTRUCTIONS

1
37

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. 3.

MAR 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03252

03275

CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO District Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home		d. STREET ADDRESS Apt. 11 7706 Alpine St.	
3. NAME OF DECEASED (Type or print) First Middle Last Barbara Lee Lovell		4. DATE OF DEATH Month Day Year March 5th 1957 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-28
9. AGE (In years last birthday) yrs. 28		IF UNDER 1 YEAR Months Days Hours Min. 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Alexandria Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Geo. P. Elliott		14. MOTHER'S MAIDEN NAME Myrtle Ruth Jacobs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. No	
17. INFORMANT R.W. Lowell		Address Apt. 11 7706 Alpine St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 ACUTE CONGESTIVE FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 HOUR DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 322.1 MALNUTRITION, CHRONIC ALCOHOLISM			INTERVAL BETWEEN ONSET AND DEATH 1 HOUR
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 21, 1957 , to MAR 3, 1957 , that I last saw the deceased alive on MARCH 3, 1957 , and that death occurred at 3:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John O. Ford M.D. 7200 MARLBORO PIKE ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) DISTRICT HEIGHTS, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-5-57	
22c. NAME OF CEMETERY OR CREMATORY Demaines Funeral Home		22d. LOCATION (City, town, or county) (State) Alexandria Va.	
23. FUNERAL DIRECTOR'S SIGNATURE WM. Demaine & Sop.		ADDRESS Alexandria Va.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Edna F. Collins	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF WITNESS [Illegible]	
13. SIGNATURE OF WITNESS [Illegible]		14. SIGNATURE OF WITNESS [Illegible]		15. SIGNATURE OF WITNESS [Illegible]	
16. SIGNATURE OF WITNESS [Illegible]		17. SIGNATURE OF WITNESS [Illegible]		18. SIGNATURE OF WITNESS [Illegible]	
19. SIGNATURE OF WITNESS [Illegible]		20. SIGNATURE OF WITNESS [Illegible]		21. SIGNATURE OF WITNESS [Illegible]	
22. SIGNATURE OF WITNESS [Illegible]		23. SIGNATURE OF WITNESS [Illegible]		24. SIGNATURE OF WITNESS [Illegible]	
25. SIGNATURE OF WITNESS [Illegible]		26. SIGNATURE OF WITNESS [Illegible]		27. SIGNATURE OF WITNESS [Illegible]	
28. SIGNATURE OF WITNESS [Illegible]		29. SIGNATURE OF WITNESS [Illegible]		30. SIGNATURE OF WITNESS [Illegible]	
31. SIGNATURE OF WITNESS [Illegible]		32. SIGNATURE OF WITNESS [Illegible]		33. SIGNATURE OF WITNESS [Illegible]	
34. SIGNATURE OF WITNESS [Illegible]		35. SIGNATURE OF WITNESS [Illegible]		36. SIGNATURE OF WITNESS [Illegible]	
37. SIGNATURE OF WITNESS [Illegible]		38. SIGNATURE OF WITNESS [Illegible]		39. SIGNATURE OF WITNESS [Illegible]	
40. SIGNATURE OF WITNESS [Illegible]		41. SIGNATURE OF WITNESS [Illegible]		42. SIGNATURE OF WITNESS [Illegible]	
43. SIGNATURE OF WITNESS [Illegible]		44. SIGNATURE OF WITNESS [Illegible]		45. SIGNATURE OF WITNESS [Illegible]	
46. SIGNATURE OF WITNESS [Illegible]		47. SIGNATURE OF WITNESS [Illegible]		48. SIGNATURE OF WITNESS [Illegible]	
49. SIGNATURE OF WITNESS [Illegible]		50. SIGNATURE OF WITNESS [Illegible]		51. SIGNATURE OF WITNESS [Illegible]	
52. SIGNATURE OF WITNESS [Illegible]		53. SIGNATURE OF WITNESS [Illegible]		54. SIGNATURE OF WITNESS [Illegible]	
55. SIGNATURE OF WITNESS [Illegible]		56. SIGNATURE OF WITNESS [Illegible]		57. SIGNATURE OF WITNESS [Illegible]	
58. SIGNATURE OF WITNESS [Illegible]		59. SIGNATURE OF WITNESS [Illegible]		60. SIGNATURE OF WITNESS [Illegible]	
61. SIGNATURE OF WITNESS [Illegible]		62. SIGNATURE OF WITNESS [Illegible]		63. SIGNATURE OF WITNESS [Illegible]	
64. SIGNATURE OF WITNESS [Illegible]		65. SIGNATURE OF WITNESS [Illegible]		66. SIGNATURE OF WITNESS [Illegible]	
67. SIGNATURE OF WITNESS [Illegible]		68. SIGNATURE OF WITNESS [Illegible]		69. SIGNATURE OF WITNESS [Illegible]	
70. SIGNATURE OF WITNESS [Illegible]		71. SIGNATURE OF WITNESS [Illegible]		72. SIGNATURE OF WITNESS [Illegible]	
73. SIGNATURE OF WITNESS [Illegible]		74. SIGNATURE OF WITNESS [Illegible]		75. SIGNATURE OF WITNESS [Illegible]	
76. SIGNATURE OF WITNESS [Illegible]		77. SIGNATURE OF WITNESS [Illegible]		78. SIGNATURE OF WITNESS [Illegible]	
79. SIGNATURE OF WITNESS [Illegible]		80. SIGNATURE OF WITNESS [Illegible]		81. SIGNATURE OF WITNESS [Illegible]	
82. SIGNATURE OF WITNESS [Illegible]		83. SIGNATURE OF WITNESS [Illegible]		84. SIGNATURE OF WITNESS [Illegible]	
85. SIGNATURE OF WITNESS [Illegible]		86. SIGNATURE OF WITNESS [Illegible]		87. SIGNATURE OF WITNESS [Illegible]	
88. SIGNATURE OF WITNESS [Illegible]		89. SIGNATURE OF WITNESS [Illegible]		90. SIGNATURE OF WITNESS [Illegible]	
91. SIGNATURE OF WITNESS [Illegible]		92. SIGNATURE OF WITNESS [Illegible]		93. SIGNATURE OF WITNESS [Illegible]	
94. SIGNATURE OF WITNESS [Illegible]		95. SIGNATURE OF WITNESS [Illegible]		96. SIGNATURE OF WITNESS [Illegible]	
97. SIGNATURE OF WITNESS [Illegible]		98. SIGNATURE OF WITNESS [Illegible]		99. SIGNATURE OF WITNESS [Illegible]	
100. SIGNATURE OF WITNESS [Illegible]		101. SIGNATURE OF WITNESS [Illegible]		102. SIGNATURE OF WITNESS [Illegible]	

RECEIVED
MAR 19 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03236

CERTIFICATE OF DEATH

03253

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>81 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		d. STREET ADDRESS <u>3820 Nicholson St</u>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>L</u> Middle <u>Macintosh</u> Last		4. DATE OF DEATH <u>March</u> Month <u>20</u> Day <u>1957</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24 1872</u> 84 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired checker</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Sanitary Commission</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired checker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Sanitary Commission</u>	
11. BIRTHPLACE (State or foreign country) <u>Winchester, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luther L. Macintosh</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-10-1001</u>	
17. INFORMANT <u>Sabell N. Coit</u> Address <u>Daughter 4408-30th St. Mt. Rainier, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 1/2 mos</u> <u>4 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/30</u> , 1956, to <u>3/20</u> , 1957, that I last saw the deceased alive on <u>3/20</u> , 1957, and that death occurred at <u>9:04</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Bmeau</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Perry St</u> DATE SIGNED <u>3/20/57</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT BMEAU</u>		<u>Mt Rainier Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fork Lincoln</u>		22d. LOCATION (City, town, or county) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley Funeral Home</u>		ADDRESS <u>3200 R.I. Ave.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 26 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>	

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

Continuation of the death certificate form, containing fields for cause of death, medical history, and other details. The text is mostly illegible due to fading and bleed-through.

BUREAU V. S.

MAR 26 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 245

03237

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>				d. STREET ADDRESS <u>5602 43rd Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Bruce</u> Last <u>McCall</u>				4. DATE OF DEATH Month <u>3</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1883</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lease Manager Gen outdoor adv.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lease Manager</u>		11. BIRTHPLACE (State or foreign country) <u>So. Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>				13. WATM. NAME <u>Wm. HORACE McCall</u>			
14. MOTHER'S MAIDEN NAME <u>Susan Combs</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>578-09-139</u>				17. INFORMANT <u>Wife</u> Address <u>same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary congestion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerotic Heart Disease</u> DUE TO (c) <u>auric fibrillation</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>Mar</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-28-57</u> , 19 <u>57</u> , and that death occurred at <u>5 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. L. Etienne</u>				ADDRESS (Street, city or town, state) <u>4713-Berwyn Rd</u>			
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE College Park, Md</u>				DATE SIGNED <u>3-28-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/1/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md 20606 Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co - Riverdale, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>April 1-1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u> Deputy	

RECEIVED

APR 3 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

03276

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>FORESTVILLE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>				c. LENGTH OF STAY IN 1b <u>25 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5482-4th Ave.</u>				e. STREET ADDRESS <u>5482 4th AVE. Forestville, Md.</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>H.</u> Middle <u>MC DANIEL</u> Last				4. DATE OF DEATH <u>MARCH</u> Month <u>12</u> Day <u>1957</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-14-1906</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles F. McDaniel</u>				14. MOTHER'S MAIDEN NAME <u>Pearl May Kendall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577 48 5242</u>		17. INFORMANT <u>Roy H. McDaniel</u> Address <u>2832 S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential hypertension (chronic)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 years.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February, 1955</u> , to <u>March 11, 1957</u> , that I last saw the deceased alive on <u>March 8, 1957</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Etienne Gallon</u> M.D.				ADDRESS (Street, city or town, state) <u>2 Parkway Dr. Forest Hill, Md.</u> DATE SIGNED <u>March 12, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Etienne Szollosi</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Switzerland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>517-11th St. N.E.</u>				24a. REC'D BY REGISTRAR <u>15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

MAR 15 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal, cremation, or removal.

VS. A15ME(5)
5M 9/55

03277

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03256

Reg. Dist. No.

243

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bowie Race Track				e. STREET ADDRESS 702 Allendale Street			
3. NAME OF DECEASED (Type or print) First Charles Middle Robert Last Mc Guinness				4. DATE OF DEATH Month March Day 27 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1887		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Night supervisor		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Thomas McGuinness				14. MOTHER'S MAIDEN NAME Margaret Frances Kennedy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215/09/2637		17. INFORMANT Dorothy Stinehcomb; Same as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, 260X DUE TO Cardiovascular renal disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus and arthritis, chronic.							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 27, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-30-57		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 S. Paul Street				24a. REC'D BY REGISTRAR DATE 3/29/57		24b. REGISTRAR'S SIGNATURE Agnes Young	

DATE SIGNED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE ALLEGED DEED

Wife Name (s)

August 1, 1907

Wife

Virginia

Wife

Wife

Wife

Wife

Wife

Wife

Wife

Wife

BUREAU V. 1

APR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03195 CERTIFICATE OF DEATH

Reg. Dist. No.

03257

245

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. RAINIER RD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C. 478-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>3841-34th St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELMER PEYTON MCINTOSH</u>				4. DATE OF DEATH Month Day Year <u>MARCH 11 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 14 1894</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>		11. BIRTHPLACE (State or foreign country) <u>Independence, Mo., U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LUTHER M. MCINTOSH</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE PEYTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-05-6424</u>		17. INFORMANT Address <u>247-TUCKERMAN ST. WASH. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>4 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 hour</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV 6</u> , 19 <u>57</u> , to <u>MAR 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAR 4</u> , 19 <u>57</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3425 12th St. N.E.</u> DATE SIGNED <u>11 MAR 57</u> ACTUAL SIGNATURE <u>John F. Brennan Jr.</u> M.D. <u>3425 12th St. N.E.</u> PHYSICIAN'S NAME (Type) <u>JOHN F. BRENNAN JR., M.D. WASH. D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CAKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Gaffell</u> ADDRESS <u>475-H-5th St. N.W. WASH.</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Joe E. Loney</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF MINISTER		16. SIGNATURE OF CLERGY		17. SIGNATURE OF OTHER		18. SIGNATURE OF OTHER		19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER		61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	
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BUREAU V. S.

MAR 13 1957

RECEIVED

03278

CERTIFICATE OF DEATH

Reg. Dist. No.

nfr

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FOREST HEIGHTS				c. LENGTH OF STAY IN 1b 1556.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 339 CREE DRIVE				d. STREET ADDRESS 8207 QUEEN ANN DRIVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANGELUS Middle Angellis Last McKENNEY				4. DATE OF DEATH Month MARCH Day 19 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7/16/99	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Accounting Dept. C.&P. Telephone Co.				10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Micheal B. Inscoe				14. MOTHER'S MAIDEN NAME Ann Elizabeth Mann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 577-01-3364		17. INFORMANT Mrs. Charles L. Densinger, 339 Cree Drive Forest Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 155 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary Carcinoma of Liver DUE TO (c) 1 1/2 year				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 10, 1957 , to March 19, 1957 , that I last saw the deceased alive on March 18, 1957 , and that death occurred at 9:25 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Etienne Szollosi M.D.				ADDRESS (Street, city or town, state) 2. Parkway Dr. Forest Hts.			
DATE SIGNED (Hd)							
PHYSICIAN'S NAME (Type) ETIENNE SZOLLOSI							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/22/57		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.							
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Campbell				ADDRESS SILVER SPRING, MD.		24. REC'D BY REGISTRAR MAR 21 1957	
24b. REGISTRAR'S SIGNATURE Carrie Campbell							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03238

CERTIFICATE OF DEATH

03259

Reg. Dist. No.

242

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General 5006				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH Month Mar. Day 7 Year 19 57				5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH April 5 1896				9. AGE (In years lost birthday) 60 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home			
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Francis E. Evans				14. MOTHER'S MAIDEN NAME Ellen L. Winters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Husband Address William M. Miles				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Viral Enteritis DUE TO (c) 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 2, 1957 to March 7, 1957 , that I last saw the deceased alive on March 7, 1957 , and that death occurred at 8:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6124 Central Ave DATE SIGNED 3/7/57							
ACTUAL SIGNATURE William Brainin M.D.				PHYSICIAN'S NAME (Type) Dr. W. Brainin			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
Capital				3-11-57			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
Washington National				Washington Pa			
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR			
Thomas Lee & Sons				3-12-57			
ADDRESS 3004 14th St. N.E.				24b. REGISTRAR'S SIGNATURE Carrie F. Campbell			

WARRANT STATE DEPARTMENT OF HEALTH—BALTIMORE 18

RECEIVED

03'94

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.				c. LENGTH OF STAY IN 1b 36 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville, Md.				d. STREET ADDRESS 6128 42rd Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6128 42rd Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mayme Pritts Myers				4. DATE OF DEATH Month Day Year March 15, 1957.			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11, 1875	
9. AGE (In years last birthday) 82 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME John Pritts		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT George F. Myers Hyattsville, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Chronic Heart Failure (b) Arteriosclerotic Heart Disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 1 week 5 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb-16, 1949, to March 15, 1957, that I last saw the deceased alive on March 14, 1957, and that death occurred at 8:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Horace H. Custis				M.D. 3119 Patterson Pl NW Wash DC 3/15/57			
PHYSICIAN'S NAME (Type) Horace H. Custis				3119 Patterson Place N Washington D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/57		22c. NAME OF CEMETERY OR CREMATOR George Washington		22d. LOCATION (City, town, or county) Hyattsville, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE MAR 21 1957		24b. REGISTRAR'S SIGNATURE Jas. Seaver	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1912		BALTIMORE		MARYLAND		MARYLAND		UNITED STATES	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		MANNER OF DEATH		CAUSE OF DEATH		DISEASE		SYMPTOMS	
CLERK		HIGH SCHOOL		METHODIST		MARRIED		SUICIDE		GUNSHOT WOUND		DEPRESSION		SUICIDE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL	
MARCH 10 1957		BALTIMORE		MARYLAND		MARYLAND		UNITED STATES		MARCH 12 1957		BALTIMORE		MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF DEPUTY CLERK		SIGNATURE OF ASSISTANT CLERK	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 1

MAR 21 1957

RECEIVED

CERTIFICATE OF DEATH

03261

Reg. Dist. No.

03279

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 6402- 7th St., N.W.	
3. NAME OF DECEASED (Type or print) First Matthew Middle J. Last O'Brien		4. DATE OF DEATH Month March Day 20 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/86
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fed. Guard		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hugh O'Brien		14. MOTHER'S MAIDEN NAME Mary Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Amy, 1911-1916/ 579-09-7287/	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemoptysis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary tuberculosis, far advanced DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February 21 1952 , to March 20, 1957 , that I last saw the deceased alive on March 20 , 19 57 , and that death occurred at 1:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) Glenn Dale Hospital Glenn Dale, Maryland	
PHYSICIAN'S NAME (Type) Moe Weiss		DATE SIGNED 3/20/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/23/57	22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	22d. LOCATION (City, town, or county) (State) Hampton Va.
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 3821-14th St. N.W. Wash. D.C.	
24a. RECEIVED BY REGISTRAR 26		24b. REGISTRAR'S SIGNATURE 26	

MAR 26 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. BROWN		MAY 15, 1957	
AGE		SEX	
65		Male	
RACE		EDUCATION	
White		High School	
OCCUPATION		PLACE OF BIRTH	
Retired		Maryland	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE	
Myocardial Infarction		Coronary Artery Disease	
PRE-EXISTING DISEASES		TREATMENT	
Hypertension		None	
DIAGNOSIS		HISTORICAL DATA	
Myocardial Infarction		Patient had been ill for several days.	
DATE OF DEATH		PLACE OF DEATH	
May 15, 1957		Home	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. Smith		J. H. Smith	
DATE		DATE	
May 15, 1957		May 15, 1957	

BUREAU V. 2

MAR 26 1957

RECEIVED

14-10-1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi		c. LENGTH OF STAY IN 1b 7 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Saint Branch Nursing Home, Powder Mill Rd.		e. STREET ADDRESS 430 Ogletown St NW	
3. NAME OF DECEASED (Type or print) OLIVE Ruth Overdorff		4. DATE OF DEATH Mar 30 19 57	
5. SEX W	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH Jan 3, 1891	9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt	11. BIRTHPLACE (State or foreign country) Pa
13. FATHER'S NAME Robert Overdorff		14. MOTHER'S MAIDEN NAME Lucy Spearman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Anson Overdorff	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary heart attack DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 57 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 30, 1957, to Mar 30, 1957, that I last saw the deceased alive on Mar 28, 1957, and that death occurred at 9:58 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L W Malin M.D.		ADDRESS (Street, city or town, state) Riverdale, Md.	
PHYSICIAN'S NAME (Type) L W Malin M.D.		DATE SIGNED 3-30-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR 2, 1957	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PENNAHUR EXT. PRIGER Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. C. ...		24a. REC'D BY REGISTRAR DATE 0 1957	
ADDRESS 254 Carroll St. N.W. D.C.		24b. REGISTRAR'S SIGNATURE James Seavey	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
DATE OF DEATH [Faint handwritten date]		PLACE OF DEATH [Faint handwritten place]		TIME OF DEATH [Faint handwritten time]	
OCCASION OF DEATH [Faint handwritten occasion]		CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
PLACE OF BIRTH [Faint handwritten place]		DATE OF BIRTH [Faint handwritten date]		SEX [Faint handwritten sex]	
OCCUPATION [Faint handwritten occupation]		EDUCATION [Faint handwritten education]		RELIGION [Faint handwritten religion]	
MARITAL STATUS [Faint handwritten status]		PREVIOUS MARRIAGES [Faint handwritten previous marriages]		PREVIOUS DEATHS [Faint handwritten previous deaths]	
SIGNATURE OF DECEASED [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]		SIGNATURE OF PHYSICIAN [Faint handwritten signature]	
SIGNATURE OF CORONER [Faint handwritten signature]		SIGNATURE OF JURY [Faint handwritten signature]		SIGNATURE OF JUDGE [Faint handwritten signature]	

BUREAU V. S.

APR 2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral director's removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03239

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 0213 4-4-57 et

Reg. Dist. No.

03263

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carroll First Middle Last		4. DATE OF DEATH March 25 19 57 Month Day Year	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sep-3-1933
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY AAFB. Cafe	9. AGE (In years last birthday) 23 yrs. IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tom Butler		14. MOTHER'S MAIDEN NAME Grace Proctor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 931932	
17. INFORMANT Rosa Proctor Address Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of the base of the skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Diver of an automobile that ran of the road and struck a tree	
20c. TIME OF INJURY Month, Day, Year 9:45 p.m. 3/ 24 19 57		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road 20e. (City or town) Forestville P. G. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED March 25, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-28-1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 901 3rd St., S. W.		24a. REC'D BY REGISTRAR MAR 28 57 24b. REGISTRAR'S SIGNATURE Quincy	

WILLIAM STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Occupation		Cause of Death	
Manner of Death		Medical History		History of Present Illness		Postmortem Examination	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	

1. Name of Deceased: [illegible] 2. Sex: [illegible] 3. Age: [illegible]

BUREAU V. 8

MAR 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral director's removal.

VS. A15ME(5)
SM 9/55

03281

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03264

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
c. LENGTH OF STAY IN lb Life				d. STREET ADDRESS Route # 301			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Roland Last Proctor				4. DATE OF DEATH Month March Day 22 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1956	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Clarence Proctor				14. MOTHER'S MAIDEN NAME Elizabeth Mildred Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Joseph Roland Proctor				Address Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/25/56		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	
22d. LOCATION (City, town, or county) (State) Upper Marlboro Md.							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch Sons Hyattsville Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 28 1957	
24b. REGISTRAR'S SIGNATURE Th. H. Hedrick							

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John J. Doe		Male		45		Jan 1, 1900		Boston, Mass.		Boston, Mass.		Heart Disease		Natural	
Occupation		Education		Marital Status		Date of Death		Place of Death		Physician's Name		Hospital Name		Coroner's Name	
Teacher		High School		Married		Mar 15, 1945		Boston, Mass.		Dr. J. A. Smith		St. Mary's Hospital		Mr. J. B. Brown	
Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Registrar		Signature of Deceased		Signature of Next of Kin		Signature of Burial Place		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
MAR 26 1945
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03282

CERTIFICATE OF DEATH

03265

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Hgts.</u>		c. LENGTH OF STAY IN 1b <u>30yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Hgts Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>7205 Gateway Blvd</u>			
3. NAME OF DECEASED (Type or print) <u>BEULAH H. PUMPELLY</u>				4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22, 1875</u>		9. AGE (In years last birthday) yrs. <u>81</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William S. Dickey</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Charles D Pumpelly</u> Address <u>7205 Gateway Blvd District Hgts. Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Insufficiency</u> DUE TO (c) <u>Hypertensive Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 weeks</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> 19 <u>47</u> to <u>March 26</u> 19 <u>57</u> that I last saw the deceased alive on <u>March 25</u> 19 <u>57</u> and that death occurred at <u>5:00</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney W. Lowry</u> M.D.				ADDRESS (Street, city or town, state) <u>7200-MARLBORO PIKE SE</u>		DATE SIGNED <u>3-26-57</u>	
PHYSICIAN'S NAME (Type) <u>SIDNEY W. LOWRY M.D.</u>				LOCATION (City, town, or county) (State) <u>DISTRICT HEIGHTS MD</u>		<u>WASH 28</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Natl. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>NW Chambliss</u>				ADDRESS <u>5125 11th St SE</u>		24a. REC'D BY REGISTRAR <u>DATE 3-29-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

CERTIFICATE OF DEATH

See Ord. No.

<p>1. NAME OF DECEASED [Faint handwritten name]</p>		<p>2. SEX [Faint handwritten sex]</p>	
<p>3. AGE [Faint handwritten age]</p>		<p>4. DATE OF BIRTH [Faint handwritten date]</p>	
<p>5. PLACE OF BIRTH [Faint handwritten place]</p>		<p>6. OCCUPATION [Faint handwritten occupation]</p>	
<p>7. MARITAL STATUS [Faint handwritten status]</p>		<p>8. CAUSE OF DEATH [Faint handwritten cause]</p>	
<p>9. MEDICAL HISTORY [Faint handwritten history]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint handwritten signature]</p>		<p>12. DATE OF DEATH [Faint handwritten date]</p>	
<p>13. PLACE OF DEATH [Faint handwritten place]</p>		<p>14. COUNTY [Faint handwritten county]</p>	
<p>15. CITY [Faint handwritten city]</p>		<p>16. STATE [Faint handwritten state]</p>	

BUREAU V. S.

APR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03240

CERTIFICATE OF DEATH

03266

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Hospital				d. STREET ADDRESS 12220 Gun Powder Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Robert Middle Peter Last Rhode				4. DATE OF DEATH Month March Day 29 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 20, 1881		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Agnes Gingell Address Beltsville, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute Myocardial Infarct. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Heart Disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-2 , 19 54 , to 3-29 , 19 57 , that I last saw the deceased alive on 3-25 , 19 57 , and that death occurred at M , from the causes and on the date stated above. ACTUAL SIGNATURE A. Dietz M.D. Hyattsville Md. DATE SIGNED 3-30-57 PHYSICIAN'S NAME (Type) Aaron Dietz							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE APR 2 '57		24b. REGISTRAR'S SIGNATURE Quelch	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. SMITH		SEX Male		AGE 45		DATE OF BIRTH Jan 15, 1912		PLACE OF BIRTH Baltimore, Md.		MARRIAGE Married	
OCCUPATION Clerk		EDUCATION High School		RELIGION Roman Catholic		MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease	
DATE OF DEATH Apr 10, 1957		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home		ATTENDING PHYSICIAN Dr. J. H. Smith		HISTORICAL DATA Patient had been ill for several days with chest pain and shortness of breath.		TESTIMONY I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF DECEASED James H. Smith		SIGNATURE OF WITNESSES John Doe, Jane Doe		SIGNATURE OF FUNERAL HOME ABC Funeral Home		SIGNATURE OF REGISTRAR Mary White		SIGNATURE OF CLERK John Black	

BUREAU V. S.

APR 2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03283 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 243

03267

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 ✓			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bowie Race Track				d. STREET ADDRESS 1219 Missouri Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Riccardi Last				4. DATE OF DEATH Month March Day 28 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-04		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electrical		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Pasquale Riccard				14. MOTHER'S MAIDEN NAME Maria Cimmento			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-07-8263		17. INFORMANT Jane Riccardi; 4238 34th Street. Mount Ranier, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/1/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home, Inc.				ADDRESS 4th Rainier		24a. REC'D BY REGISTRAR APR 2 1957	
				24b. REGISTRAR'S SIGNATURE Agnes Young		DATE SIGNED March 28, 1957	

STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John F. Kennedy	
Sex		Male	
Age		35	
Date of Birth		11-22-20	
Place of Birth		Boston, Mass.	
Occupation		President of the United States	
Cause of Death		Acute myocardial infarction	
Manner of Death		Natural	
Signature of Examiner		[Signature]	
Date of Death		11-22-63	
Place of Death		Washington, D.C.	

RECEIVED
BUREAU V. S.
 APR 2 1957

03284

CERTIFICATE OF DEATH

Reg. Dist. No. 03268

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> COUNTY <u>Prince Georges Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home - 4111 Beall St.</u>				e. STREET ADDRESS <u>14911 Beall St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Nathaniel</u> Middle <u>Harrison</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1891</u>	9. AGE (In years and birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter - Construction</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>David Strother Robinson</u>				14. MOTHER'S MARDEN NAME <u>Mary Baggett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579057902</u>		17. INFORMANT <u>Wife</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar 20</u> , 19 <u>56</u> , to <u>Mar 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 26</u> , 19 <u>57</u> , and that death occurred at <u>5:00</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Reilly</u>				ADDRESS (street, city or town, state) <u>7409 Varney St. Landover Hills, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. Reilly</u>				DATE SIGNED <u>Mar 29 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/30/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

141

BUREAU V. S.

MAR 29 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REMOVAL OF BODY TO D.C. CLEARED BY PHONE (DR. MALONEY)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03196

CERTIFICATE OF DEATH

03269

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Ranier</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Mt. Ranier</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>				d. STREET ADDRESS <u>2704 Allison St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rose</u> First <u>Rodman</u> Middle <u>Lost</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1957</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 14, 1892</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Max Brotsky</u>				14. MOTHER'S MAIDEN NAME <u>Soria Patinowitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Norman Kal</u>		Address <u>4000 Mass. Ave. N.W. Wash, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Osteogenic sarcoma - GENERALIZED METASTASES</u> <u>196X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u> <u>PAGETS DISEASE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>56</u> , to <u>3-30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-30</u> , 19 <u>57</u> , and that death occurred at <u>10:40 AM</u> , from the causes and on the date stated above.							
1. ACTUAL SIGNATURE <u>C. David Cooper</u>				M.D. <u>1730 EYE ST. N.W. WASH. DC</u> DATE SIGNED <u>3/30/57</u>			
PHYSICIAN'S NAME (Type) <u>C. DAVID COOPER, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elesavetgrad Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wash, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky</u>				ADDRESS <u>9505 3501-14th St. N.W. WASH. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>April 5 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Savery</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED MAX BRADY		2. SEX MALE		3. AGE 45	
4. DATE OF DEATH APR 7 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. PLACE OF BIRTH MASSACHUSETTS	
10. OCCUPATION MANAGER		11. EDUCATION HIGH SCHOOL		12. RELIGION CATHOLIC	
13. MARITAL STATUS MARRIED		14. DATE OF MARRIAGE 1935		15. NAME OF SPOUSE MARY BRADY	
16. NAME OF PHYSICIAN DR. J. J. BRADY		17. NAME OF HOSPITAL ST. JOSEPH'S		18. NAME OF NURSE MRS. J. J. BRADY	
19. NAME OF CORONER JOHN J. BRADY		20. NAME OF BURIAL PLACE ST. JOSEPH'S CEMETERY		21. NAME OF MINISTER FR. J. J. BRADY	
22. NAME OF FUNERAL HOME ST. JOSEPH'S		23. NAME OF CEMETERY ST. JOSEPH'S		24. NAME OF INTERMENT ST. JOSEPH'S	
25. NAME OF BURIAL PLACE ST. JOSEPH'S		26. NAME OF MINISTER FR. J. J. BRADY		27. NAME OF FUNERAL HOME ST. JOSEPH'S	
28. NAME OF CEMETERY ST. JOSEPH'S		29. NAME OF INTERMENT ST. JOSEPH'S		30. NAME OF BURIAL PLACE ST. JOSEPH'S	

BUREAU V. 1

APR 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03270
7/30

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		c. LENGTH OF STAY IN 1b 21 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8805 48th Avenue				d. STREET ADDRESS 1 8805 48th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma Jane Rook				4. DATE OF DEATH March 13, 19 57			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10, 1870	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86		IF UNDER 24 HRS. Hours 86 Min. 86			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Edwin Rook				14. MOTHER'S MAIDEN NAME Mary Elizabeth Allison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.		17. INFORMANT Address Thomas Edwin Rook; Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease DUE TO 442X Arteriosclerosis Candilans, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis (c) Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 13, 1957			
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF March 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				ADDRESS F. Gasch's Sons Hyattsville, Maryland.		24. REGISTRAR'S SIGNATURE John Smith	

RECEIVED BY REGISTRAR
DATE **MAR 15 1957**

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
Thomas Edwin Hook		37 years		Male		White		Nov. 10, 1957	
Place of Birth		Usual Residence		Cause of Death		Manner of Death		Signature of Medical Examiner	
New Britain, Conn.		1000 Main Avenue, New Britain, Conn.		Coronary Artery Disease		Natural		[Signature]	
Occupation		Education		Marital Status		Social History		Remarks	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

BUREAU V. 8

MAR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03241

CERTIFICATE OF DEATH

03271

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chertsey		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hosp		d. STREET ADDRESS 15704-40 Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Raymond Russell		4. DATE OF DEATH Month Day Year March 22, 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/20/86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired accountant G. A. O.		9. AGE (In years last birthday) 70	
11. b. KIND OF BUSINESS OR INDUSTRY b. PLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME William J. Russell		14. MOTHER'S MAIDEN NAME Jennie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nina B. Russell (wife)		Address same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Cerebral Vascular Disease - Cong. - Resp. Failure DUE TO (b) Pulmonary Edema, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 days 7 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 20, 1954, to March 22, 1957, that I last saw the deceased alive on March 21, 1957, and that death occurred at 4:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon W. Kelley		DATE SIGNED M.D. 6/24-4/15/57 Hyattsville Md 3/22/57	
PHYSICIAN'S NAME (Type) Gordon W. Kelley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/25/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Calmar Manor Pr. Georges Md
23. FUNERAL DIRECTOR'S SIGNATURE Halley Funeral Home		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

MAR 26 '57

MAR 26 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle (Mary P.) Last Saville		4. DATE OF DEATH Month March Day 17 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 March 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Forrest Saville		14. MOTHER'S MAIDEN NAME Elizabeth A. Reid	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Father --		Address 2612 Kirkwood Pl, Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 6 mos preg. 776 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Marginal Placenta DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. 11. Month 19 Day 19 Year 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 16, 1957 to March 17, 1957 , that I last saw the deceased alive on March 17, 1957 , and that death occurred at 6:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon W. Kelley		DATE SIGNED 3/17/57	
PHYSICIAN'S NAME (Type) Dr. Gordon Kelley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch & Sons, Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE MAR 21 1957	
24b. REGISTRAR'S SIGNATURE Paul J. Hall			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2077254XV1

OUTLINE

BUREAU

MAR 21 1968

MB 34

1507X

DECEMBER 1974

BUREAU V. S.

MAR 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral director OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to funeral director, cremation, or removal.

VS. A15ME(5)
5M 9/55

03285

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheltenham</u>	c. LENGTH OF STAY IN 1b <u>16 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheltenham</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Van Brady Road</u>		d. STREET ADDRESS <u>1 Van Brady Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>William</u> Last <u>Savoy</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25 1915</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tobacco</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Emanuel Savoy</u>	
14. MOTHER'S MAIDEN NAME <u>Ida Proctor</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>Bethie Savoy, same as #2</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>442x</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>March 12, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>
22d. LOCATION (City, town, or county) <u>Rosaryville, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Collins</u> ADDRESS <u>4239 Hunt Pl., N.E.</u>		24. REC'D BY REGISTRAR <u>W. J. ...</u> DATE <u>MAR 18 '57</u>	
25. REGISTRAR'S SIGNATURE			

REAU V. E.

MAR 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03274

03243

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale Md.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>15 Hyattsville Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Engle Island Memorial Hosp.</i>				d. STREET ADDRESS <i>5205-58th Ave.</i>			
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>M.</i> Last <i>SCHRODER</i>				4. DATE OF DEATH Month <i>Mar.</i> Day <i>25</i> Year <i>1957</i>			
5. SEX <i>Fe.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 14, 1880</i>	9. AGE (In years last birthday) <i>77</i> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James Whalen</i>				14. MOTHER'S MAIDEN NAME <i>Anna Savage</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes</i>		17. INFORMANT <i>Daughter - Mrs. Ed. Shanahan</i> Address <i>734 Womans Rd. Belts</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Myocardial Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i> (c) _____				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>15 years.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Longstanding heart failure</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <i>11</i> p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <i>May 29</i> , 1954, to <i>March 25</i> , 1957, that I last saw the deceased alive on <i>March 25</i> , 1957, and that death occurred at <i>5 P.</i> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Hans Wodak</i>				DATE SIGNED <i>30-C RIDGE Rd GREENBELT, MD.</i>			
PHYSICIAN'S NAME (Type) <i>HANS WODAK</i>				ADDRESS <i>30-C RIDGE Rd GREENBELT, MD.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3-29-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard H. Hubbard</i>				ADDRESS <i>4107 Wilkens Ave.</i>		24a. REC'D BY REGISTRAR <i>MAR 27 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>James Leary</i>			

RECEIVED

03286

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

348

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Silver Hill			
c. LENGTH OF STAY IN 1b 4 weeks				d. STREET ADDRESS 14434 St Barnabard			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4434 - St Barnabard				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Catharine Rose Sheehan				4. DATE OF DEATH Mar 4 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 3, 1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Argentina		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Timothy Joseph Sheehan				14. MOTHER'S MARDEN NAME Mary Ellen Grace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-10-7535		17. INFORMANT James A. Sheehan		Address 3636-16 45th St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 4, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				ADDRESS Riverdale, Md		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
				DATE MAR 7 1957		Carrie Campbell	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. 2

MAR 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

003287

CERTIFICATE OF DEATH

Reg. Dist. No.

03276
230

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Muirkirk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Muirkirk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rossville Rd</u>		d. STREET ADDRESS <u>1 Rossville Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Jane</u> Last <u>Snowden</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-24-1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Matthews</u>		14. MOTHER'S M maiden name <u>Rebecca Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Virginia Snowden - Rossville Rd.</u>	
17. INFORMANT <u>Virginia Snowden - Rossville Rd.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Atherosclerosis -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		INTERVAL BETWEEN ONSET AND DEATH <u>1 d -</u> <u>20 yrs</u> <u>10 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3-22-1957</u> to <u>3/7/57</u> , that I last saw the deceased alive on <u>3/6/57</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. Warren</u>		DATE SIGNED <u>3/7/57</u>	
PHYSICIAN'S NAME (Type) <u>J. M. Warren</u>		ADDRESS <u>467 N. St. N.W. Wash DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-10-57</u>		22b. DATE THEREOF <u>3-10-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Queen's Chapel Cem Muirkirk Md.</u>		22d. LOCATION (City, town, or County) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u>		24a. REC'D BY REGISTRAR <u>John D. Donette</u>	
ADDRESS <u>467 N. St. N.W. Wash DC</u>		24b. REGISTRAR'S SIGNATURE <u>John D. Donette</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>2. SEX</p> <p><i>Male</i></p>	
<p>3. AGE</p> <p><i>45</i></p>		<p>4. DATE OF BIRTH</p> <p><i>1922</i></p>	
<p>5. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>		<p>6. OCCUPATION</p> <p><i>Teacher</i></p>	
<p>7. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>8. MANNER OF DEATH</p> <p><i>Natural</i></p>	
<p>9. DATE OF DEATH</p> <p><i>March 10, 1957</i></p>		<p>10. TIME OF DEATH</p> <p><i>10:30 AM</i></p>	
<p>11. PLACE OF DEATH</p> <p><i>Home</i></p>		<p>12. SIGNATURE OF PHYSICIAN</p> <p><i>John Doe</i></p>	
<p>13. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESSES</p> <p><i>John Doe</i></p>	

BUREAU V. S.

MAR 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG212 3-26-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

03277

03244

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 10 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS 5502 Volta Avenue			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Caroline Middle Spicer Last Spicer				4. DATE OF DEATH Month March Day 4 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 Oct. 1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs. Doris Gotch Baldensburg, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Congestive Failure 204.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Branchiopneumonia DUE TO (c) Leukemic Leukemia, Adeno Ca Rectal Polyp				INTERVAL BETWEEN ONSET AND DEATH 2 hrs 1 week 3 yr + 6 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/25/54 , 19 54 , to 3/4/57 , 19 57 , that I last saw the deceased alive on 3/4 , 19 57 , and that death occurred at 3:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville Md DATE SIGNED 3/4/57							
ACTUAL SIGNATURE Gordon W Kelley M.D. 6/24-11/54							
PHYSICIAN'S NAME (Type) Dr. Gordon Kelley							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		3/6/57		Evergreen Cemetery		Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE	
						24b. REGISTRAR'S SIGNATURE DATE	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1912	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE OF DEATH		MANNER OF DEATH	
JAN 20 1957		BALTIMORE, MARYLAND		JAMES H. HARRIS		NATURAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE OF DEATH		MANNER OF DEATH	
JAN 20 1957		BALTIMORE, MARYLAND		JAMES H. HARRIS		NATURAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	

BUREAU V. 3

MAR 7 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

03245

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Cheverly Md.</u>			
c. LENGTH OF STAY IN 1b <u>6 Days</u>				d. STREET ADDRESS <u>3115 Cheverly Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Stanier</u> Last			4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>19 57</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-71</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Supt Nut and Bolt Company</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>England</u>		11. BIRTHPLACE (State or foreign country) <u>U S A</u>		
13. FATHER'S NAME <u>John Stanier</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>159 22 0892A</u>		17. INFORMANT <u>James C. Stanier (Son)</u>		Address <u>Same as Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5 JAN</u> , 19 <u>57</u> , to <u>21 MAR</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>20 MAR</u> , 19 <u>57</u> , and that death occurred at <u>4:50A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHEVERLY MD</u> DATE SIGNED <u>3/21/57</u>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.			PHYSICIAN'S NAME (Type) <u>Dr. Kehoe</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation 3/22/57</u>		22b. DATE THEREOF <u>3/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pittsburg</u>		22d. LOCATION (City, town, or county) (State) <u>Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 26 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Kehoe</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BIRTH [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		MARITAL STATUS [Faint text]	
PREVIOUS ILLNESS [Faint text]		PREVIOUS SURGERY [Faint text]		PREVIOUS TRAUMA [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	

BUREAU V. S.

MAR 26 1957

RECEIVED

03246

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b 14 Mrs. 55 Min. Capitol Hghts. 36			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 5906 F Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Roland Middle A. Last Sweeney				4. DATE OF DEATH Month Mar. Day 14 Year 1957			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1912	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender.		10b. KIND OF BUSINESS OR INDUSTRY Employed		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Ambrose Sweeney				14. MOTHER'S MAIDEN NAME Jane Ida Bassford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Sweeney Helen Ruth (Wife)		Address Same As Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of liver - Alcoholism (c) Esophageal varices - peptic ulcer							INTERVAL BETWEEN ONSET AND DEATH 24 H.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from 3-13 , 19 57 , to 3-14 , 19 57 , that I last saw the deceased alive on 3-14 , 19 57 , and that death occurred at 12:55 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE D. A. Churim		M.D. P. G. G. H.		ADDRESS (Street, city or town, state)		DATE SIGNED 3/14/57	
PHYSICIAN'S NAME (Type) Dr. Madigan		Prince Georges' Gen. Hospital, Cheverly, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/16/57	22c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery		22d. LOCATION (City, town, or county)		(State) Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.				24a. REC'D BY REGISTRAR DATE 18 '57		24b. REGISTRAR'S SIGNATURE Dr. H. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03197

CERTIFICATE OF DEATH

Reg. Dist. No.

03280

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tokoma Park, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Tokoma Park, Maryland.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7008 Poplar avenue				d. STREET ADDRESS 7008 Poplar avenue,.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last EDGAR MAYO Tabb				4. DATE OF DEATH Month Day Year March 5 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 4, 1867	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Groceryman		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Dougla C. Tabb				14. MOTHER'S MAIDEN NAME Woodrow Mc Dowell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Annie S Bell Tokoma Park, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis of Lung & Right Shoulder Joint 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? Sinite Arteriosclerosis Generalized YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 7-8 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Apr. 1946, to 5 March 1957, that I last saw the deceased alive on 4 March 1957, and that death occurred at 1:15 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.B. Queen M.D. 7112 Willow Ave 5 Mar 1957 PHYSICIAN'S NAME (Type) M. B. QUEEN Takoma Park, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				ADDRESS F. Gasch's Sons Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE MAR 7 1957	
24b. REGISTRAR'S SIGNATURE A. J. Hedrick							

CERTIFICATE OF DEATH

08187

1. NAME OF DECEASED JAMES J. HENRY		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1892		5. PLACE OF BIRTH New York, N.Y.	
6. OCCUPATION Retired		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1915		9. PLACE OF MARRIAGE New York, N.Y.		10. NAME OF SPouse Mary J. Henry	
11. DATE OF DEATH 1957		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural	
16. SIGNATURE OF PHYSICIAN J. J. Smith		17. SIGNATURE OF REGISTRAR J. J. Smith		18. SIGNATURE OF DECEASED J. J. Henry		19. SIGNATURE OF WITNESS J. J. Henry		20. SIGNATURE OF DECEASED J. J. Henry	

BUREAU V. 2

MAR 7 1957

RECEIVED

03247

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Geo. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George County Hospital</u>		d. STREET ADDRESS <u>421-70th St.</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN EDWARD TAYLOR</u>		4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-57</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard E. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Viola May Roy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Viola May Roy</u>		Address <u>421-70th St. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ERYTHROBLASTOSIS FETALIS</u> DUE TO <u>(RH-) of MOTHER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>20 MIN.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-25</u> , 19 <u>57</u> , to <u>3-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-25</u> , 19 <u>57</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Max M. Herzberg</u> M.D.		ADDRESS (Street, city or town, state) <u>7016 - GREIG ST.</u>	
PHYSICIAN'S NAME (Type) <u>MAX M. HERZBERG, M.D.</u>		DATE SIGNED <u>SEAT-PLEASANT MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-1-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Meth. Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Seat Pleasant Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Thambon Co.</u>		ADDRESS <u>517-11th St. S.E.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>W. W. Thambon</u>	
DATE <u>APR 4 '57</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077326XV4

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

03243

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 118 15th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Samuel Middle Taylor Last				4. DATE OF DEATH Month March Day 20 Year 19 57				
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1911		
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ross Taylor				14. MOTHER'S MAIDEN NAME Mary Fosque				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Gilbert Taylor; Same address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 835X DUE TO Conditions, if any, which gave rise to immediate cause (b) Laceration of liver, spleen and lung. (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Run over by tractor-trailer.						
20c. TIME OF INJURY Month, Day, Year Hour 5.30 p. m. 3-20-57 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Vacant lot		20f. (City or town) (County) (State) Chillum Pr. Geo. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 20, 1957				
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Washington D. C.		
23. FUNERAL DIRECTOR'S SIGNATURE Barbour Funeral Home, 48-K-St., N.E. Wash. D.C.				24a. REC'D BY REGISTRAR DATE 22 57		24b. REGISTRAR'S SIGNATURE Overman		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

BUREAU V. S.

03249

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 301 W 92nd St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Eva		Middle Tewlow		Last		4. DATE OF DEATH Month March Day 3 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady		10b. KIND OF BUSINESS OR INDUSTRY Dept Store		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Harry				14. MOTHER'S MAIDEN NAME Lena			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT Louis Ghyat- 2026 Address Ocala Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Fibrillation 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis						INTERVAL BETWEEN ONSET AND DEATH 30 minutes 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/14 , 19 57 , to 3/3 , 19 57 , that I last saw the deceased alive on 3/3 , 19 57 , and that death occurred at 7:30 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Lena Lewinsky				ADDRESS (Street, city or town, state) 4300 Kewwood Dr, 4K, 4K, 4K, 4K			
PHYSICIAN'S NAME (Type) Lena Lewinsky				DATE SIGNED 3/3/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-5-57		22c. NAME OF CEMETERY OR CREMATORY Herring Run		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lena Lewinsky				ADDRESS 2100 Gutter Place		24a. REC'D BY REGISTRAR BAR 5 '57	
				24b. REGISTRAR'S SIGNATURE Overman			

MAR 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03288

Item 8, Film G211, 3/7/57 bh

CERTIFICATE OF DEATH

03284

Reg. Dist. No. 234

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton				c. LENGTH OF STAY IN 1b 8 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARGARET First IRENE Middle THORNE Last				4. DATE OF DEATH March 3rd. Month March Day 3rd. Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 Aug. 15- 1884	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas F. Wood				14. MOTHER'S MAIDEN NAME Maria Burgess			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hattie A. Thorne Address 8201- Livingston Road S.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Decomensation-Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) General Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 days unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural Cause			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not-while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 57 , to March 3 , 19 57 , that I last saw the deceased alive on March 2 , 19 57 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Paul C Van Natta M.D. 5440 Silver Hill Rd SE				PHYSICIAN'S NAME (Type) PAUL C VAN NATTA Washington 28 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 6-57		22c. NAME OF CEMETERY OR CREMATORY Epiphany Episcopal Cemetery		22d. LOCATION (City, town, or county) (State) Forestville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. ADDRESS 1661- Good Hope Road S.E. Washington 20, D.C.				24a. REC'D BY REGISTRAR MAR 5 1957		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1880		BALTIMORE		MD		USA		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
LABORER		HEART DISEASE		NATURAL		JAN 15 1925		BALTIMORE		MD		USA		USA	
EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT		TEMPERATURE		PULSE	
HIGH SCHOOL		METHODIST		WHITE		WHITE		5' 8"		170		98.6		72	
MARITAL STATUS		PREVIOUS MARRIAGES		SINGLE		NONE		YES		NO		YES		NO	
MARRIED		NONE		YES		NO		YES		NO		YES		NO	
DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CITY	
JAN 15 1925		JAMES H. HARRIS		JAN 15 1925		BALTIMORE		MD		USA		USA		BALTIMORE	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF BURIAL PLACE		NAME OF MINISTER		NAME OF CHURCH		NAME OF CEMETERY		NAME OF CEMETERY	
JAMES H. HARRIS		BALTIMORE HOSPITAL		JAMES H. HARRIS		BALTIMORE CEMETERY		JAMES H. HARRIS		BALTIMORE CHURCH		BALTIMORE CEMETERY		BALTIMORE CEMETERY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF BURIAL PLACE		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF CEMETERY		SIGNATURE OF CEMETERY	
JAMES H. HARRIS		BALTIMORE HOSPITAL		JAMES H. HARRIS		BALTIMORE CEMETERY		JAMES H. HARRIS		BALTIMORE CHURCH		BALTIMORE CEMETERY		BALTIMORE CEMETERY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 15 1925		JAN 15 1925		JAN 15 1925		JAN 15 1925		JAN 15 1925		JAN 15 1925		JAN 15 1925		JAN 15 1925	

RECEIVED
MAR 5 1957
BUREAU V. S.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03289

CERTIFICATE OF DEATH

Reg. Dist. No.

03285
734

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>	c. LENGTH OF STAY IN 1b <u>2</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>MARION</u> First <u>FRANCIS</u> Middle <u>THORPE</u> Last		4. DATE OF DEATH Month <u>MARCH</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 13, 1916</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Kearney</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wm. J. Thorpe</u>		14. MOTHER'S MAIDEN NAME <u>Wm. J. Thorpe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Wm. J. Thorpe</u>		Address <u>Accokeek MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY FAILURE</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO (c) <u>LEFT HEMI PARALYSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>2 1/2 mos.</u> <u>2 1/2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>01</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 28, 1957</u> , to <u>Mar. 15, 1957</u> , that I last saw the deceased alive on <u>Mar. 15, 1957</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Chen</u>		DATE SIGNED <u>ACCOKEEK</u>	
PHYSICIAN'S NAME (Type) <u>PAUL CHEN</u>		<u>MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>March 18, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>	22d. LOCATION (City, town, or county) (State) <u>Adams Hill MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Heart Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Carrie Campbell</u>	
ADDRESS <u>1111</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	
DATE <u>MAR 19 1957</u>			

MAR 19 1957

RECEIVED

03250

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH Prince Georges' o. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Groome			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Oliver Last Tucker				4. DATE OF DEATH Month Mar. Day 10 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1874	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Edward Tucker				14. MOTHER'S MAIDEN NAME Lucindia King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Catherine Tucker-733 10th St., S.E., Washington, D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary - Vascular Thrombotic Disease DUE TO (c) 2 yrs.						INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1, 1957 to Mar 10, 1957 , that I last saw the deceased alive on Mar 9, 1957 , and that death occurred at 11:38 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. Sasscer M.D.				ADDRESS (Street, city or town, state) Upper Marlboro, Md. (3-105)			
PHYSICIAN'S NAME (Type) James G. Sasscer, M. D.				DATE SIGNED Upper Marlboro, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/57		22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) (State) Forestville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Attorney [Signature]				ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE 3-15-57	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

03290

CERTIFICATE OF DEATH

03287

Reg. Dist. No.

243

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Maryland				c. LENGTH OF STAY IN 1b 1 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 177 Tokoma Park, Md			
d. STREET ADDRESS 1100 Linden Avenue,.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Florence Gertrude Tydings				4. DATE OF DEATH Month Mar Day 3 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 31, 1884	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Gabriel Butler				14. MOTHER'S MAIDEN NAME Katherine Suit			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Bernard G. Tydings,		Address Tokoma Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis c myocardial infarction DUE TO 18 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO Generalized Arteriosclerosis DUE TO 14 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right Hemiplegia - 12/29/56							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bowie Md				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 2/10 , 19 57 , to 3/3 , 19 57 , that I last saw the deceased alive on 3/2 , 19 57 , and that death occurred at 12:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bowie Md DATE SIGNED 3/3/57 ACTUAL SIGNATURE H. James Kurtz M.D. RFD PHYSICIAN'S NAME (Type) H. James Kurtz							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR MAR 6 1957	
24b. REGISTRAR'S SIGNATURE Agnes Jungling							

BUREAU V. S.

MAR 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 03251
 CERTIFICATE OF DEATH

03288

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>North Carolina</u> b. COUNTY <u>Birmingham</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>18 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				d. STREET ADDRESS <u>R. F. D.</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Pearl Lilia Walker</u>				4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-06 1889</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Robert C. East</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Cannon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Hospital records</u>				Address <u>Cheverly Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branchial Pneumonia</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebro Vascular accident</u> DUE TO (c) <u>4 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Cerebro Vascular accident</u> <u>14 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. 11. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Cheverly</u>				20f. (County) <u>Prince Georges</u>		20f. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>3/13</u> , 19 <u>57</u> , to <u>3/31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/31</u> , 19 <u>57</u> , and that death occurred at <u>2:20 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3404 CHEVERLY AVE</u> DATE SIGNED <u>3/31/57</u> ACTUAL SIGNATURE <u>John Kehoe</u> M.D. PHYSICIAN'S NAME (Type) <u>Dr. John Kehoe</u> <u>CHEVERLY, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ruffin Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ruffin North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 3 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

BUREAU V. S.

APR 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 0212 3-26-57 et

CERTIFICATE OF DEATH

03289

03252

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Charles</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheserly md.</u>				c. LENGTH OF STAY IN 1b <u>50 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				d. STREET ADDRESS <u>Waldorf md 08x02</u>			
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>Warthen</u> Last <u>Warthen</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1869</u> <u>6-29-1869</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>08</u> Days <u>11</u> Hours <u>57</u> Min.		IF UNDER 24 HRS. Months <u>08</u> Days <u>11</u> Hours <u>57</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer ret</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George F. Warthen</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Victoria Graves</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Daughter</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>typhlophor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ad. Cerebral vascular accident</u> (c) <u>generalized arterio-sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>several year</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 19th</u> , 19 <u>57</u> , to <u>May 11th</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 11th</u> , 19 <u>57</u> , and that death occurred at <u>3:20</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4314 Gallatin St. Hyattsville Md</u> DATE SIGNED <u>M.D.</u> ACTUAL SIGNATURE <u>T. L. Bergemann</u> PHYSICIAN'S NAME (Type) <u>TILL BERGEMANN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <input checked="" type="checkbox"/>		22c. NAME OF CEMETERY OR CREMATORY <u>St Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stonett Funeral Home Waldorf Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>18 57</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Reel</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE		OCCUPATION	
JAMES A. SMITH		45		M		W		M		C	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
MAR 18 1957		BALTIMORE, MD		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST	
TIME OF DEATH		PLACE OF BURIAL		CITY		STATE		COUNTRY		CITY	
10:00 AM		CATHOLIC CHURCH		BALTIMORE		MD		USA		BALTIMORE	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF MINISTER		NAME OF WITNESS		NAME OF WITNESS	
DR. J. H. SMITH		JOHN J. SMITH		CATHOLIC CHURCH		FR. J. H. SMITH		JOHN J. SMITH		JOHN J. SMITH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE		SIGNATURE OF MINISTER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
 MAR 18 1957
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03290

03190

CERTIFICATE OF DEATH

Reg. Dist. No.

730

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park				c. LENGTH OF STAY IN 1b 5 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.				d. STREET ADDRESS 5020 Quebec St			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5020 Quebec St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary A. Weber				4. DATE OF DEATH Month Day Year March 13, 1957.			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 14, 1879	
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Crimmin				14. MOTHER'S MAIDEN NAME Mary Cusack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Eugene J. Weber College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3.8 yrs years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-12 , 19 57 , to 3-13 , 19 57 , that I last saw the deceased alive on 3-12 , 19 57 , and that death occurred at 10:10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Adolph M.D.				ADDRESS (Street, city or town, state) 1432 QUEENS CHATEL RD		DATE SIGNED 3/13/57	
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER				HYATTSVILLE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/57		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR MAR 15 1957	
				24b. REGISTRAR'S SIGNATURE <i>John Adolph</i>			

BUREAU V. S.

MAR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03291

Reg. Dist. No. 272

03291

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Hillside</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6301 Walker Mill Road S.E.</u>				d. STREET ADDRESS <u>6301 Walker Mill Road S.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Stewart</u> Middle <u>Milton</u> Last <u>Weber</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 17, 1875</u>	9. AGE (in years last birthday) <u>81 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Weber</u>				14. MOTHER'S MAIDEN NAME <u>Candice Elizabeth Condo</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Jennie Weber, same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442X</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 16, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lock Haven Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>3-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAR 26 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 4-11-57 et

03253

CERTIFICATE OF DEATH

03292

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 7 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Martin Welte				4. DATE OF DEATH Month Day Year 3-25-1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-1-76/ 1878	9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millworker		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address William Kyle Capital Heights, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) thrombosis due to pyelonephritis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) gangrene of R leg due to arterio sclerosis DUE TO (c) generalized arterio sclerosis						INTERVAL BETWEEN ONSET AND DEATH 5 days 7 days year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio sclerosis heart 06 years & complete failure a						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3-18-57 , 19 57 , to 3-25 , 19 57 , that I last saw the deceased alive on 3-25 , 19 57 , and that death occurred at 4:45 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Vic Koppen M.D.				ADDRESS (Street, city or town, state) 4314 Galt St DATE SIGNED Mar 28 '57			
PHYSICIAN'S NAME (Type) T. Bergmann							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/57		22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery		22d. LOCATION (City, town, or county) (State) West Virginia, Wheeling	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR MAR 28 '57			
				24b. REGISTRAR'S SIGNATURE Overman			

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03293

CERTIFICATE OF DEATH

03293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1957</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 18 1913</u> 9. AGE (In years last birthday) <u>44</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Willie Friend</u>				14. MOTHER'S MAIDEN NAME <u>Edna Colston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Hospital records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3-8</u> , 19 <u>57</u> , to <u>3-10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-10</u> , 19 <u>57</u> , and that death occurred at <u>6:40</u> P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Gordon W. Kelley</u> M.D. <u>6-124-41st Ave Hyattsville Md</u>				DATE SIGNED <u>3/11/57</u>			
PHYSICIAN'S NAME (Type) <u>Gordon W. Kelley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-14-57</u>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington & Sons</u> ADDRESS <u>467 N. St. N.W.</u>				24a. REC'D BY REGISTRAR <u>MAR 15 57</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur</u>			

CERTIFICATE OF DEATH

Page One

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>March 15, 1957</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. MEDICAL HISTORY <i>None</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
19. SIGNATURE OF CORONER <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JUDGE <i>John Doe</i>	
22. SIGNATURE OF CLERK <i>John Doe</i>		23. SIGNATURE OF REGISTRAR <i>John Doe</i>		24. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
25. SIGNATURE OF ASSISTANT <i>John Doe</i>		26. SIGNATURE OF CHIEF <i>John Doe</i>		27. SIGNATURE OF DEPUTY <i>John Doe</i>	
28. SIGNATURE OF CLERK <i>John Doe</i>		29. SIGNATURE OF REGISTRAR <i>John Doe</i>		30. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
31. SIGNATURE OF ASSISTANT <i>John Doe</i>		32. SIGNATURE OF CHIEF <i>John Doe</i>		33. SIGNATURE OF DEPUTY <i>John Doe</i>	
34. SIGNATURE OF CLERK <i>John Doe</i>		35. SIGNATURE OF REGISTRAR <i>John Doe</i>		36. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
37. SIGNATURE OF ASSISTANT <i>John Doe</i>		38. SIGNATURE OF CHIEF <i>John Doe</i>		39. SIGNATURE OF DEPUTY <i>John Doe</i>	
40. SIGNATURE OF CLERK <i>John Doe</i>		41. SIGNATURE OF REGISTRAR <i>John Doe</i>		42. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
43. SIGNATURE OF ASSISTANT <i>John Doe</i>		44. SIGNATURE OF CHIEF <i>John Doe</i>		45. SIGNATURE OF DEPUTY <i>John Doe</i>	
46. SIGNATURE OF CLERK <i>John Doe</i>		47. SIGNATURE OF REGISTRAR <i>John Doe</i>		48. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
49. SIGNATURE OF ASSISTANT <i>John Doe</i>		50. SIGNATURE OF CHIEF <i>John Doe</i>		51. SIGNATURE OF DEPUTY <i>John Doe</i>	
52. SIGNATURE OF CLERK <i>John Doe</i>		53. SIGNATURE OF REGISTRAR <i>John Doe</i>		54. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
55. SIGNATURE OF ASSISTANT <i>John Doe</i>		56. SIGNATURE OF CHIEF <i>John Doe</i>		57. SIGNATURE OF DEPUTY <i>John Doe</i>	
58. SIGNATURE OF CLERK <i>John Doe</i>		59. SIGNATURE OF REGISTRAR <i>John Doe</i>		60. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
61. SIGNATURE OF ASSISTANT <i>John Doe</i>		62. SIGNATURE OF CHIEF <i>John Doe</i>		63. SIGNATURE OF DEPUTY <i>John Doe</i>	
64. SIGNATURE OF CLERK <i>John Doe</i>		65. SIGNATURE OF REGISTRAR <i>John Doe</i>		66. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
67. SIGNATURE OF ASSISTANT <i>John Doe</i>		68. SIGNATURE OF CHIEF <i>John Doe</i>		69. SIGNATURE OF DEPUTY <i>John Doe</i>	
70. SIGNATURE OF CLERK <i>John Doe</i>		71. SIGNATURE OF REGISTRAR <i>John Doe</i>		72. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
73. SIGNATURE OF ASSISTANT <i>John Doe</i>		74. SIGNATURE OF CHIEF <i>John Doe</i>		75. SIGNATURE OF DEPUTY <i>John Doe</i>	
76. SIGNATURE OF CLERK <i>John Doe</i>		77. SIGNATURE OF REGISTRAR <i>John Doe</i>		78. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
79. SIGNATURE OF ASSISTANT <i>John Doe</i>		80. SIGNATURE OF CHIEF <i>John Doe</i>		81. SIGNATURE OF DEPUTY <i>John Doe</i>	
82. SIGNATURE OF CLERK <i>John Doe</i>		83. SIGNATURE OF REGISTRAR <i>John Doe</i>		84. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
85. SIGNATURE OF ASSISTANT <i>John Doe</i>		86. SIGNATURE OF CHIEF <i>John Doe</i>		87. SIGNATURE OF DEPUTY <i>John Doe</i>	
88. SIGNATURE OF CLERK <i>John Doe</i>		89. SIGNATURE OF REGISTRAR <i>John Doe</i>		90. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
91. SIGNATURE OF ASSISTANT <i>John Doe</i>		92. SIGNATURE OF CHIEF <i>John Doe</i>		93. SIGNATURE OF DEPUTY <i>John Doe</i>	
94. SIGNATURE OF CLERK <i>John Doe</i>		95. SIGNATURE OF REGISTRAR <i>John Doe</i>		96. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
97. SIGNATURE OF ASSISTANT <i>John Doe</i>		98. SIGNATURE OF CHIEF <i>John Doe</i>		99. SIGNATURE OF DEPUTY <i>John Doe</i>	
100. SIGNATURE OF CLERK <i>John Doe</i>		101. SIGNATURE OF REGISTRAR <i>John Doe</i>		102. SIGNATURE OF ARCHIVIST <i>John Doe</i>	

BUREAU V. B.

MAR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove card in papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G212 3-20-57 et

CERTIFICATE OF DEATH

03294

03255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Walter Whittaker		4. DATE OF DEATH Month Day Year Mar 10 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-73
9. AGE (In years full birthday) 84 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) Blackburn, Lancastershire Co., England		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Thomas		14. MOTHER'S MAIDEN NAME Hannah Howarth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 16-218-03-2856A	
17. INFORMANT Alice Whittaker (Wife)		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO BROWHO PNEUMONIA (b) CALCIFIC AORTIC STENOSIS (c) DUE TO ARTERIOSCLEROTIC HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 24, 1957, to March 10, 1957, that I last saw the deceased alive on March 10, 1957, and that death occurred at 10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Dineen		DATE SIGNED 3/10/57	
PHYSICIAN'S NAME (Type) Dr. N. Comeau		M.D. 3503 Perry St. MT Rainier Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/13/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1. DEATH NO. _____		2. COUNTY _____	
3. NAME OF DECEASED _____		4. SEX _____	
5. AGE _____		6. DATE OF BIRTH _____	
7. PLACE OF BIRTH _____		8. OCCUPATION _____	
9. MARITAL STATUS _____		10. CAUSE OF DEATH _____	
11. MEDICAL HISTORY _____		12. SIGNATURE OF PHYSICIAN _____	
13. SIGNATURE OF CORONER _____		14. SIGNATURE OF DEATH REGISTRAR _____	
15. SIGNATURE OF WITNESS _____		16. SIGNATURE OF WITNESS _____	
17. SIGNATURE OF WITNESS _____		18. SIGNATURE OF WITNESS _____	
19. SIGNATURE OF WITNESS _____		20. SIGNATURE OF WITNESS _____	
21. SIGNATURE OF WITNESS _____		22. SIGNATURE OF WITNESS _____	
23. SIGNATURE OF WITNESS _____		24. SIGNATURE OF WITNESS _____	
25. SIGNATURE OF WITNESS _____		26. SIGNATURE OF WITNESS _____	
27. SIGNATURE OF WITNESS _____		28. SIGNATURE OF WITNESS _____	
29. SIGNATURE OF WITNESS _____		30. SIGNATURE OF WITNESS _____	
31. SIGNATURE OF WITNESS _____		32. SIGNATURE OF WITNESS _____	
33. SIGNATURE OF WITNESS _____		34. SIGNATURE OF WITNESS _____	
35. SIGNATURE OF WITNESS _____		36. SIGNATURE OF WITNESS _____	
37. SIGNATURE OF WITNESS _____		38. SIGNATURE OF WITNESS _____	
39. SIGNATURE OF WITNESS _____		40. SIGNATURE OF WITNESS _____	
41. SIGNATURE OF WITNESS _____		42. SIGNATURE OF WITNESS _____	
43. SIGNATURE OF WITNESS _____		44. SIGNATURE OF WITNESS _____	
45. SIGNATURE OF WITNESS _____		46. SIGNATURE OF WITNESS _____	
47. SIGNATURE OF WITNESS _____		48. SIGNATURE OF WITNESS _____	
49. SIGNATURE OF WITNESS _____		50. SIGNATURE OF WITNESS _____	
51. SIGNATURE OF WITNESS _____		52. SIGNATURE OF WITNESS _____	
53. SIGNATURE OF WITNESS _____		54. SIGNATURE OF WITNESS _____	
55. SIGNATURE OF WITNESS _____		56. SIGNATURE OF WITNESS _____	
57. SIGNATURE OF WITNESS _____		58. SIGNATURE OF WITNESS _____	
59. SIGNATURE OF WITNESS _____		60. SIGNATURE OF WITNESS _____	
61. SIGNATURE OF WITNESS _____		62. SIGNATURE OF WITNESS _____	
63. SIGNATURE OF WITNESS _____		64. SIGNATURE OF WITNESS _____	
65. SIGNATURE OF WITNESS _____		66. SIGNATURE OF WITNESS _____	
67. SIGNATURE OF WITNESS _____		68. SIGNATURE OF WITNESS _____	
69. SIGNATURE OF WITNESS _____		70. SIGNATURE OF WITNESS _____	
71. SIGNATURE OF WITNESS _____		72. SIGNATURE OF WITNESS _____	
73. SIGNATURE OF WITNESS _____		74. SIGNATURE OF WITNESS _____	
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85. SIGNATURE OF WITNESS _____		86. SIGNATURE OF WITNESS _____	
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89. SIGNATURE OF WITNESS _____		90. SIGNATURE OF WITNESS _____	
91. SIGNATURE OF WITNESS _____		92. SIGNATURE OF WITNESS _____	
93. SIGNATURE OF WITNESS _____		94. SIGNATURE OF WITNESS _____	
95. SIGNATURE OF WITNESS _____		96. SIGNATURE OF WITNESS _____	
97. SIGNATURE OF WITNESS _____		98. SIGNATURE OF WITNESS _____	
99. SIGNATURE OF WITNESS _____		100. SIGNATURE OF WITNESS _____	

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may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03292

CERTIFICATE OF DEATH

03295

Reg. Dist. No. 242

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE'S COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN 1b X2 Suitland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3202 Ryan Drive				d. STREET ADDRESS 3202 Ryan Drive			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAISY Middle PAULINE Last WILSON				4. DATE OF DEATH Month March Day 25 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 20, 1881	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Robey				14. MOTHER'S MAIDEN NAME Sarah Mouldin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Irene Millsap, 3202 Ryan Dr. Suitland, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 1950, to March 25, 1957 , that I last saw the deceased alive on March 25, 1957 , and that death occurred at 7:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James I. Boyd, M.D.				ADDRESS (Street, city or town, state) 8200 Marlboro Pike, Forestville, Maryland			
PHYSICIAN'S NAME (Type) JAMES I. BOYD, M.D.				DATE SIGNED 3-26-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/28/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.				ADDRESS 517 11th St. S.E., Wash., D.C.		24a. REC'D BY REGISTRAR DATE 3-29-57	
				24b. REGISTRAR'S SIGNATURE Carrie Campbell			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REG. 1001 100

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
NAME OF PHYSICIAN [Illegible]		NAME OF FUNERAL HOME [Illegible]		NAME OF BURIAL PLACE [Illegible]	
NAME OF NEXT OF KIN [Illegible]		NAME OF WITNESS [Illegible]		NAME OF REGISTRAR [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF FUNERAL HOME [Illegible]		SIGNATURE OF BURIAL PLACE [Illegible]	
SIGNATURE OF NEXT OF KIN [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	

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